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***Raising awareness of clinical practice from an existential perspective with
clients affected by cancer***

An Interpretative Phenomenological Analysis of practitioners' experiences

By

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This project I dedicate to Nena.

Abstract

The existential/phenomenological approach to therapy is one that addresses many of the issues arising following a cancer diagnosis such as the sudden realisation of one's mortality, loneliness, anxiety, worry and loss of meaning in life.

This study explores qualified existential therapists' experience of working with clients diagnosed with cancer. Additionally, an attempt has been made to explore participants' theoretical understanding of the existential approach to therapy as well as its implications for their clinical practice.

A qualitative methodology was used and six semi-structured interviews were conducted in order to provide a rich understanding of the participants' experiences. Six qualified existential practitioners with experience in working with clients affected by cancer participated in the study. A Thematic Analysis (TA) and an Interpretative Phenomenological Analysis (IPA) were applied in the analysis of the data.

A Thematic Analysis of the first question that attempted to describe participants' working knowledge of the existential approach was conducted. Consecutively, Interpretative Phenomenological Analysis was applied in order to obtain each individual's subjective understanding of their experience and also to allow the researcher's personal conception and interpretation of the data to be utilized.

The analysis of the data collected revealed three emerging themes: (1) Therapists' conceptualisation of the existential approach; (2) Emotional responses to working with clients diagnosed with cancer and (3) Implications in clinical practice with clients with cancer.

This study highlights the emotional impact of working with clients affected by cancer upon therapists. Work with a client with cancer involves working with uncertainty, anxiety and death. Therapists might also come to a realisation of their own mortality or even develop death and health anxieties. Lastly, the analysis also indicates implications regarding clinical practice and what is expected of therapists when working in this context.

Key words: Cancer; Qualitative; IPA; TA; Existential; Psychotherapy

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Reflexive Preface

Research projects usually arise from the researcher's personal and/or professional interests or in an attempt to inform and develop their clinical practice. A series of events and experiences, as well as my personal and professional interests and unanswered questions in relation to psychotherapeutic work, led to the development of this research project. Due to the nature of this study and the sensitivity of the issues it explores, it is important to reflect upon the reasons prompting me to explore this particular experience as well as any assumptions and anticipated outcomes. In particular, reflections will follow in line with the different stages of the research process: designing the study, forming the research questions, carrying out the interviews as well as conducting the analysis and writing up the results.

Beginning of the journey

Around the time I was coming to a decision regarding my research topic, my godmother was diagnosed with cancer. The diagnosis came as a shock to me followed by feelings of denial, great sadness and fear of what could happen next. At that time I was still living in the UK and my family, including my godmother, were in Greece. Being miles away and only visiting Greece a few times a year made me feel quite detached from the situation. There was a significant incident that took place at one of my visits back home that I believe triggered my initial thoughts of this research topic. My godmother needed to be taken to the hospital for one of her chemo treatments and as there was nobody else available to accompany her I offered to go with her. Attending chemotherapy with her,

and meeting other people going through the same process made me aware of the physical and emotional pain patients go through and the loneliness they experience. I stayed with her at the hospital for twelve hours. I was really shocked by the number of people attending cancer treatments, the wide range of their ages and the different attitudes people held upon their experiences. What impressed me the most was the difference in the discussions taking place among patients when the relatives left the ward. When their relatives were not around, patients tended to talk about the illness, the treatment options, their experiences of managing pain and the discomfort they often felt. However, the scene seemed to change whenever a relative entered the ward. Discussions became more casual. They were even talking about the weather. I was surprised by the fact that it was actually the patients who were trying to protect their relatives from what they were going through and questions arose within me as to who supports them with what they are going through.

When cancer approaches your family there are feelings of fear and anxiety in relation to what is going to happen next. From my experience of my relative being diagnosed I felt forced to live in the present and tried spending more time with her, as the future was too ambiguous. In an attempt to understand the illness and relieve my anxiety I begun searching and reading about it. The fact that there is no satisfactory answer to what causes cancer; there is no relief as the 'why' remains unanswered, means that everybody, including myself, is a potential patient.

On a personal level, I was shocked by the illness's impact on the physicality of people and became aware of my feelings towards what it means to be ill, going in and out of

hospitals and the fear of dying. Visiting hospitals has always been intimidating for me. The smell, the pain expressed in people's faces, the thought of regular visits for treatments and the physical pain made me facing the reality of cancer. In addition, the lack of psychological support for ill people treated within the Greek health system made me feel upset and frustrated. While being a trainee therapist I felt tense and urged to emotionally support people with cancer. I felt some sort of responsibility towards them, as I understood the importance of psychological support and at the same time frustrated that there was not something I could do about it.

This experience led to my initial research proposal which suggested an exploration of the experience of clients diagnosed with cancer who had received existential therapy. I was interested to see whether patients who had the opportunity to receive psychological support whilst undergoing cancer treatment actually found it helpful and if so in which ways. On a professional level, I was very interested in this topic and believed it could provide useful insight, as research on the existential-phenomenological approach is still quite limited. In addition, an attempt would have been made to look at the subjective lived experiences of the clients. Unfortunately, the process of getting ethical approval from the NHS was very time consuming, causing many delays with my study plans and was financially straining. I was under a lot of pressure and eventually I had to make a decision on how I was going to proceed. With great disappointment I had to let go of my initial research idea and consider a modification of my research topic.

Change of route

While I was conducting my first literature review I became aware of the scarcity of case studies exploring in greater depth the experiences of psychological therapy for clients diagnosed with cancer. In addition, it was evident that the majority of case studies focused mainly on the client failing to attend to the therapist's experience and feelings. I consequently began contemplating the idea of conducting a study that would focus on the therapist's experience.

As I was nearly completing my training as a counselling psychologist, I began wondering how it would feel if one of my clients was diagnosed with cancer. I was aware of my feelings arising from my relative's condition and also of the importance and closeness of the therapeutic relationship. Through my clinical practice I worked with vulnerable clients to whom I felt very close to. Especially with the ones I had the opportunity to work with long term, I experienced that the therapeutic relationship was valuable to both of us. Questions kept arising as to how it would feel to me as a therapist when my own client becomes diagnosed with cancer or some other terminal illness or asks for support while undergoing treatment or even how it would feel if/ when the client eventually dies? These questions informed my new project that aimed to explore existential therapists' experience of working with clients going through this difficult process.

One of the reasons I found this topic appealing was that it had an impact on my developing at the time identity, as an existential counselling psychologist. In addition,

given the limited amount of research in relation to the existential approach, I felt I was contributing to the field. In retrospect, I realised that there was much more to my decision of this particular research topic than what I had initially considered. My experiences at the time and my godmother's condition had strongly influenced me and definitely played a significant role in my choice. I have actually come to the conclusion that through this study I was hoping to give some meaning to what my godmother was going through and her consequent death thus I chose to look at cancer rather than some other illness.

Drawing the map of this journey

An additional reason that prompted me to conduct this project was my admiration for practitioners working with terminally ill clients. I consider this kind of practice extremely useful and important and at the same time very challenging. As dying can be a very lonely process therapy can be a good way of offering support to the clients and providing a space for exploration of their feelings. Considering my struggle to visit hospitals and be around people in great physical and emotional pain, I found this work very challenging. Despite the fact that I admire this context of practice I have found myself deliberately avoiding working within hospital settings. Inevitably, my views have coloured this study and therefore an attempt is made in this chapter and in the entire thesis to recognise their presence and reflectively elaborate upon them. Beyond any doubt there were preconceived ideas, assumptions and anticipations that accompanied me during this research journey. I deliberately attempted to allow some space and recognise them as they appeared in the different stages of the study. A research diary was kept throughout this process that assisted in my self-reflection and the composition of the reflective sections of this thesis.

Having explored the personal experiences that led to the development of this study it is also important to elaborate upon my professional experience and identity as an existential counselling psychologist. Lacking the experience of working with clients diagnosed with cancer adds an '*outsider's*' perspective to my experience of this study and involves a genuine interest from my side in understanding participants' experiences. A possible hidden desire leading me to conduct this study might have been to '*test the*

water' before deciding to jump in. This explains my initial hesitation and insecurity to engage in this kind of practice due to my inexperience and fear of the unknown.

Reflecting back, there were several reasons that attracted me to studying existential psychotherapy. I was intrigued by the philosophical underpinnings of the existential attitude, its focus on the human lived experience and the idea that human beings have to keep searching to understand the realities of the human condition and existence (van Deurzen & Baker, 2005). Being of Greek origin, I am familiar with a wide range of philosophical traditions that throughout the years have been integrated in my ways of being. Philosophical questions or rather the philosophical attitude is therefore at the centre of my personal development and professional stance within the field of counselling psychology.

In my opinion, the way the world is perceived influences our ways of being and attitudes in life. I therefore see existential therapy as an attitude, rather than a unified theory, that assists us in living more deliberately through confronting the limitations and givens of existence such as meaninglessness, freedom, death and isolation; and learning to live with the tensions they evoke. In terms of therapeutic practice, I believe that the existential attitude offers the practitioner the freedom to be creative while emphasising ontological and ontic exploration as well as intersubjective meaning.

Throughout my training and clinical practice I have attempted to integrate the scientist and practitioner identities. One of the challenges, as Burry and Strauss (2006) suggest, is finding a scientific frame that is also consistent with the counselling psychology values

and the emphasis on the therapeutic relationship and of '*being*' rather than '*doing*'. I believe their common ground can be personal reflection. Consequently, my efforts in this project and generally in my professional journey are to be a reflective scientist-practitioner. Research is an important ingredient for effective therapy and a significant characteristic of the counselling psychologist's identity. Consequently, this research also intends to shed light on what existential therapy means to practitioners claiming to be working from this vantage point.

Having reflected upon my identity as a counselling psychologist I will now elaborate upon my thoughts and experience of conducting this research study. Recognising my limited research experience I decided to choose a topic that would be meaningful and would contribute to my future professional development. Although I find qualitative methods to be very appealing and relevant to the topic of research as well as my own professional philosophy, applying such a method brings many challenges. I will further elaborate upon those challenges in the following chapters. As mentioned previously, I began this project with great enthusiasm. I was looking forward to conducting a research project that would be meaningful to me and would constitute a new experience. As this was a first attempt to conduct a qualitative research I was anxious regarding the interview and analysis processes but also curious regarding the findings. Guidance and support from my supervisor throughout the research process has been invaluable and I am deeply grateful to her for clarifying the path for me.

Cultural influences

In qualitative research the researcher's role is highly significant. Reflecting upon my involvement in this study it is important to present the cultural elements that have influenced me as a person and as a professional. A brief presentation will therefore follow in relation to the Greek and the UK cultures and people's views in relation to mental health and cancer.

At the age of eighteen I moved to the UK in order to study psychology and I stayed there for a total of eight years. Living between two countries has been a difficult yet a great learning experience. Given my young age and the length of time I lived in the UK I believe I got accustomed to the culture and mentality of people and also accommodated certain aspects of UK mentality. There are several differences between Greek and UK culture. Firstly, the UK is a multicultural country whereas Greece is largely homogenous in terms of ethnicity, language and religion. However, in the last two decades there has been a significant rise in the number of economic immigrants moving to Greece from Asia, Africa and the Balkans (Malikiosi-Loizos, & Giovazolias, 2013).

Furthermore, Greek culture is traditionally regarded as a collectivistic society. While collectivistic cultural frames focus their attention on groups, individualistic cultural frames focus their attention on the individual. According to Triandis (1995) three core belief systems constitute the value basis of individualism: valuation of personal interdependency and freedom of choice, personal uniqueness, and personal achievement.

Moreover, individualism promotes the importance of knowing one's beliefs and values and behaving in accordance with this no matter what the context.

In accordance with the individualistic-collectivistic distinction, researchers have found that some countries are highly collectivistic; others highly individualistic and others stand in the middle of the continuum. Two of the countries researchers have shown interest in are Greece and the UK. Trandis and Vassiliou (1972) have found that the Greek culture is highly collectivistic. Greek culture has been characterized as having a strong emphasis on the in-group with the collective achievement of that group having a central value. Furthermore, family relationships have been found to be central in the Greek culture. By contrast, English culture has been found to be highly individualistic. The English culture has been characterized as one that stresses the significance of individual needs and individual achievement.

As Malikiosi-Loizos, & Giovazolias (2013, p. 1) state: *'Although Greece is currently considered to be right in the middle of the individualistic-collectivistic spectrum (Mylonas, Gari, Giotsa, Pavlopoulos, & Panagiotopoulou, 2006), one can notice the reality that parents, siblings, as well as close friends are still a major source of social support for Greek people in order to talk about their problems and find solutions (Malikiosi-Loizos, Christodoulidi, & Gialamas, 2010)'. Furthermore, collectivistic cultural frames focus on the 'interdependency between individuals, the centrality of family, and the importance of social unity and harmony within in-groups' (Newman & Erber, 2002, p.167).*

It is also interesting to look at people's attitudes towards mental illness as there seems to be a significant difference between the two countries since Greece is one of the countries that hold negative attitudes towards mental illness as research suggests (Economou, 2005). One out of two Greek people identify mentally ill people as '*mad*', '*dangerous*' or '*criminal*'. According to Ekonomou (2005) when Greek participants were asked whether they would have a problem living next to a schizophrenic, a person who was in prison for a serious crime offence and someone who suffers from HIV, 44% answered that they would have a problem living next to a person having schizophrenia. In addition, when participants were asked whether they would have a problem working with a schizophrenic, 50% answered that they would. Furthermore, in another study, Stergiou (2005) compared the attitudes of Greek participants with American and German participants, in relation to their answer to the following question: '*Do you believe that people suffering from schizophrenia are a public danger because of their violent behaviour?*' 74% of Greek people, 18% of the German participants and 17% of Americans answered positively. These results indicate a significant difference between Greek participants and participants from other countries upon the issue of mental illness. Having explored the cultural differences between the two countries a brief presentation of the field of psychology and counselling will follow.

It was only in the 1980's that psychology and counselling received a place in the Greek higher education institutes. In particular, psychology was part of the School of Philosophy at the Greek Universities until 1984 when it was established as a separate and autonomous department. Ever since, psychology and counselling trainings as well as counselling services have begun emerging and are still developing.

During my psychotherapy training I began seeking for a placement in order to accumulate my clinical hours. I was surprised by the wide range of services and organisations offering support on every possible human problem, difficulty or client group that existed in the UK. Today, several years later, as a Programme Leader of a training programme in counselling at a college in Greece, I am surprised, in a negative way, by the lack of services and people's hesitation in setting up counselling and therapy services as well as trusting trainees and volunteers.

Finding a balance between those two countries and the different views they hold on psychological support and mental health made me want to better understand what happens when that kind of support is available to people. This idea began developing when I accompanied my godmother to a private hospital in Greece where no psychological support was available to patients and then visiting a counselling service within the Oncology Department of a hospital in South London. Despite the variance in the availability of services between the two countries, there is a significant difference in people's attitudes towards seeking psychological support. It seems Greek people are more hesitant to seek help and the reasons provided above could offer a possible explanation. In a way, all the above possibly influenced the development of psychological services. Consequently, it is only recently that counselling services and psychological support became widely known, available and '*socially-acceptable*'. However, Greece is still a long way from where the UK stands.

The limited funding not only affects the development of counselling services but impacts upon campaigns regarding cancer prevention. A study by Chouliara et al, (2010)

highlights the difference in knowledge, attitudes toward Breast Self- Examination and health-related personality.

Looking at the issues of illness and death variations in the views of people can be observed. As a collectivistic society, strongly influenced by religion, Greek culture tends to view quality of life as strongly linked with family. Consequently, patients are thought to be better off when they are surrounded by family members hence there is a strong tendency for people wanting to die within their home environment. On a different note, individualistic societies tend to focus on the individual's needs and his/her quality of life refers to the best medical or professional help he/she could receive.

As a consequence of the above, from my experience it is not uncommon for people within Greek society to be misinformed regarding their actual health condition or diagnosis. It is not uncommon for relatives to choose not to disclose information in order to '*protect*' the patient. According to Mystikidou et al (2004) country and culture strongly influence whether, how and how much to tell cancer patients concerning their diagnosis. The diagnosis of cancer affects both family structure and family dynamics regardless of cultural origin. '*In most cases patients' families, in an effort to protect them from despair and a feeling of hopelessness, exclude the patient from the process of information exchange*' (Mystikidou et al, 2004, p. 147).

Assumptions and anticipations

A number of assumptions and anticipations might have stemmed from the study of the literature and research available in relation to this particular topic of study. Furthermore, very significant is the role of personal knowledge and experience as previously discussed. Even though my assumptions were limited as I had not had a similar experience with the one under investigation, there were still assumptions about the possible outcome of this study.

This study attempts to explore the participants' understanding of the existential approach and my expectation was that there would be some common ground between the participants' views and an in depth exploration of the existential issues related to the clients' condition will be at the centre of the therapeutic work. Being a trainee existential therapist myself, I wanted my study to be a contribution, no matter how small, to the limited research available on this particular field. In addition, I assumed that the issues that cancer clients would bring to the therapeutic encounter would be existential in nature; such as mortality, death anxiety, loneliness, reviewing life; thus existential therapy might be one that best fits this client group.

I anticipated the participants' responses to include both positive and negative experiences in regards to clinical practice with clients with cancer for instance discussing the difficulties as well as the positive aspects. I assumed participants would struggle with their client's possible death and feelings in relation to the changes in their lives. An additional anticipation was the therapist's feelings towards a possible choice of

the client to refuse medical treatment. This idea was closely linked to my relative's experience who eventually decided not to continue with cancer treatments. My wish as a prospective existential therapist would be to allow my client to have this option however; I presume this is not easy for the therapist. Attempting to put myself in the therapist's shoes, I am not sure what my reaction would be to such a decision but I believe I would feel proud for my client and feel sorrow at the same time.

The above chapter provided information regarding my personal and professional stance, as well as an illustration of the reasons why I developed an interest in conducting this particular study. I can now see how my experiences and my decision to explore this particular topic were meaningful to me as well as feel that what my relative was going through was not all in vain but that her suffering could lead to something useful, a research project. I consequently recognise my personal involvement with the subject also by being an existential practitioner and I intended to attend to my personal stance as much as possible through practicing reflexivity and by attending to my own biases and reflecting upon the ways in which they influence my interpretation of my participants' experiences.

Review of the Literature

'The struggle itself...is enough to fill a man's heart.'

Albert Camus (1955, p. 111)

'The myth of Sisyphus'

The above quote was used as an introduction to this study as I thought it illustrates not only the cancer client's condition but also the practitioner's engagement with the client diagnosed with cancer, as it emerged from this research. This study is looking at the experience of existential practitioners who have worked with clients with cancer and aims to provide some clarity and understanding of their lived experience.

Rationale of Literature Review

Existential-phenomenological approaches in psychology are based upon the philosophical movements developed in the nineteenth and twentieth century. Phenomenology and existentialism are considered the most influential movements of the twentieth-century philosophy. There is a strong debate on whether phenomenology and existentialism belong together as movements or whether they are even compatible with one another (Wrathall and Dreyfus, 2006). A brief account of these movements will be provided below followed by their application to clinical practice with emphasis to their relevance to the particular topic of study. The second part of this review aims at presenting the issues around psychological intervention to clients diagnosed with cancer referring to relevant, existing literature and research.

An attempt will be made below to unpack the main ideas forming the existential approach to clinical practice. It is often believed that what distinguishes existential therapy from other forms of therapy is its philosophical nature. However, is it not the fact that it is philosophically grounded that distinguishes existential therapy from other approaches, as all approaches are underpinned by philosophical assumptions. It is what those ideas are and much more. For this reason it was considered important to look at what those ideas are and who are the main thinkers representing existential philosophy and therapeutic practice.

Phenomenology and existentialism

Phenomenology, is concerned with the experience of phenomena, how they are captured as conscious experience. As Finlay (2011, p. 3) succinctly states '*phenomenology invites us to slow down, focus on, and dwell with the 'phenomenon' – the specific qualities of the lived world being investigated*'. As a movement it was founded early in the twentieth century by Edmund Husserl (1859-1938) aiming to study '*at things themselves*' as they appear in consciousness. Followers of Husserl that have extended his work and contributed significantly to the development of phenomenology and existential doctrines have been Martin Heidegger (1889–1976), his student, Karl Jaspers (1883–1969) who applied phenomenology to psychology, Maurice Merleau-Ponty (1908-1961) who extended Heidegger's being-in-the-world to the bodily experience and Jean-Paul Sartre (1905-1980).

Heidegger's work has had the greatest impact upon the existential practice offering practitioners new ways of understanding human experience. His book *'Being and Time'* has been a major influence to Jean Paul Sartre, Maurice Merleau-Ponty and other existentialists. Heidegger similarly to Husserl aimed to move away from traditional philosophy and go back *'to the things themselves'* as they appear to us. He wanted to find out *'what is it about us and the world that enables us to encounter the world'* and begins by questioning *'what is the meaning of being'* (Barnett, 2009, p. 8). For Heidegger human beings or *'Dasein'* cannot be detached from the world and the environment rather they are *'beings-in-the-world'*. Da-sein consists of both its *facticity*, having been thrown in the world at a particular place and time and also *Existenz*, always having the possibility for personal choice (Solomon, 2005). Consequently, human beings should be considered as constantly being in relation to their environment, their world and recognising the facticity of their lives that cannot be changed but also their freedom and responsibility to choose. In addition, Heidegger has provided extensive reflections on the issues of guilt, anxiety, death and authenticity.

Søren Kierkegaard (1813–1855), is thought to be the founder of existentialism. He attempted to emphasise the individual and move away from *'the collective idea and philosophical systems'* (Solomon, 2005, p. 1). Kierkegaard's view on what it means to live a worth living life by facing the inevitable difficulties and contradictions in life is closely linked to psychotherapeutic aims. He offered an exploration of human struggle and claimed that the acceptance of it is at the core of existence. Kierkegaard and Sartre have provided fruitful ideas on the subject of authenticity too. The simplest understanding of authenticity is being true to one self. *'Dasein'* can be authentic as long

as he moves away from the *'they'* and attempts to find its own possibilities and recognise death as being one. In addition, for Heidegger fear is inauthentic as it is a state directed outside oneself whereas anxiety is authentic as it has no external object but is immediately related to the human beings' being-in-the-world (Dreyfus & Wrathall, 2006).

Kierkegaard's reflections upon the issue of anxiety provide a different approach to understanding mental health. In contrast with the ordinary symptom-alleviation attitude that dominates psychotherapeutic practice, *'anxiety must be considered the starting point of a well-lived life'* (van Deurzen, 1997, p.13). Kierkegaard links the concept of anxiety with the concept of freedom but also unfreedom. *'In anxiety the possibility of freedom presents itself, but in anxiety a human being also becomes unfree'* (Grøn, 2008, p. ix). Human beings cannot escape anxiety. They should therefore learn to live with it and learn from it. As Kierkegaard claims *'whoever has learned to be anxious in the right way has learned the ultimate'* (Kierkegaard, 1844, p.155). Thus he provides a first possible goal of therapy. According to Kierkegaard human beings are caught in a tension between the finite and the infinite, the temporal and the eternal, *'their everyday experience and the demands of the universal or eternal'*. In the process to overcome this opposition we become anxious and when we plunge completely into the infinite or too deeply into the finite we experience despair (van Deurzen, 1997, p. 11). However, this seems an impossible task. Despair is a sickness of the spirit. Van Deurzen (1997) applies this to psychotherapeutic practice by setting the therapist's task being to explore *'whether the supposedly sick person is actually sick or whether the supposedly healthy person is perhaps actually sick'* (Kierkegaard, 1849, p.23). In short, despair is the

feeling that one's life is not going well, that life is not worth living and it is impossible to be.

Jean Paul Sartre (1943) has been a significant figure of existentialism. He provided valuable writings on relationships, freedom of intention rather than successful action, authenticity and bad faith. Sartre claims that accepting the absurdity of life, human beings have to create and make it meaningful. It was Ludwig Binswanger (1881-1966) and Medard Boss (1903-1990), Swiss psychiatrists who followed Heidegger's ideas and incorporated them into their practice opening the way for the development of existential psychotherapy.

Merleau-Ponty (1962) reminds therapists to pay attention to the physical beings in the therapy room. His contribution to the field of existential psychotherapy is also significant. The clients' movements, body postures and responses should be carefully observed and phenomenologically explored. Their embodiment to the world needs to be explored and ambiguity allowed being. *'It is through my body that I understand other people just as it is through my body that I perceive 'things'' as he claims* (Merleau-Ponty, 1962, p. 216). The same applies to the therapist as their bodies can be a source of useful information.

For the existential thinkers mentioned previously, it is the individuality of each human being that needs to be uncovered. Denying an absolute goal or a universal meaning of life they emphasise freedom, responsibility and aiming at living authentically. Those

ideas have been incorporated into existential practice and at occasions become goals of therapy.

Key concepts of existential thinking will be briefly presented below in order to get an understanding of how those philosophical ideas have been implicated into clinical practice and their relevance to this particular research project. Furthermore, the issues arising following a cancer diagnosis will be unpacked and a critical view of the psychological approaches applied will be explored. Lastly, existing research relevant to the topic of study will be presented.

Existential issues explored

Key themes often addressed in existential psychotherapy, deriving from the philosophical traditions explored above will be further discussed in order to provide a richer view of this particular approach to therapy whilst focusing on their relevance to this particular topic of investigation. van Deurzen's quote summarises the meaning of existential thinking:

'Existential thinking is an attempt to think about everyday human reality in order to make sense of it, and is probably as old as the human ability to reflect' (van Deurzen, 1997, p. 1).

According to the *Dictionary of Existential Psychotherapy and Counselling* the universal meaning of life is the search for understanding of the human condition or for a network of connections and values that make sense of it (van Deurzen & Kenward, 2005). Philosophers and existential practitioners have shared their personal view on life's meaning, or the lack of it. Nietzsche's philosophical ideas and Frankl's life experiences that led to the development of logotherapy are briefly described below as their contribution is considered valuable to the development of existential psychotherapy.

Humans are fundamentally looking for greater context and values for which they want to live for and Frankl's logotherapy derives from this idea. Viktor Frankl was an Austrian neurologist and psychiatrist but most importantly a Holocaust survivor. His experience of surviving concentration camps whilst losing all of his family prompted the

development of a form of therapy aiming at creating meaning and purpose in life. Deriving from the Greek word 'logos' (λόγος) Frankl came to realise the importance of finding meaning in all life situations even the toughest ones. He claims that *'man should not ask what the meaning of his life is, but rather must recognize that it is he who is asked. In a word, each man is questioned by life; and he can only answer to life by answering for his own life; to life he can only respond by being responsible'* (Frankl, 1984, p.131).

Some of the techniques used in logotherapy include: Socratic questioning, paradoxical intention, appealing technique and de-reflection. Paradoxical intention is a very useful technique often used by existential therapists. The client is encouraged to imagine the worst case scenario, his greatest nightmare that the only logical response to it is laughter. This way the client is able to get a perspective and clarity of his problem through detaching himself from it. This technique is based on the assumption that individuals can choose their stance towards their psychological difficulties. De-reflection technique uses the client's capacity for self-transcendence. The client is asked to rise above his huge problem by focusing on something even bigger and positive (Frankl, 1984).

Frankl claims that each individual has a meaning that no one else can fulfil. However, all those individual meanings fall into three general categories: what one accomplishes or gives to the world in terms of his creations, what one takes from the world in terms of encounters and experiences and one's stance towards suffering a fate that has no power over (Frankl, 1988). His categories of meaning can provide strategies to help the client who is in a crisis of meaning. Suffering can have a meaning if it changes one for the

better but even when there is no hope of escaping suffering and death. Frankl claims that there is meaning in demonstrating to others or to oneself that one can suffer and die in dignity (Yalom, 1980). He distinguishes two kinds of meaning: *meaning of the moment* (understanding of everyday life) and *ultimate meaning* (understanding of greater principles). He claims that struggling for purpose in life or wrestling with the question of whether there is a meaning to life is not in itself a pathological phenomenon.

Similarly, Nietzsche viewed life as a battle that requires all efforts and energy, a battle worth fighting for and winning. Winning should come with exhaustion and peace and sleep will be the reward (van Deurzen, 1997). ‘*..Half your life is done, and it was pain and error through and through: why do you still seek on? Precisely this I seek: The reason why!*’ (Nietzsche, 1974, p. 61). Like Sisyphus who found meaning in his life from rolling the same stone up a mountain again and again. Similarly, Merleau-Ponty claimed that humans need to find out how to give meaning to their lives through the incarnate experience of being alive (van Deurzen, 2009). In ‘*Ecce homo*’ Nietzsche writes that the first note for Zarathustra was made in 1881. The three core doctrines of ‘*Thus spoke Zarathustra*’ are: The *Superman*, the *eternal recurrence* and the *will to power*. At the outset of the book the proposition that ‘*God is dead*’ and that Superman is to replace him, Nietzsche begins a philosophy of life. For him the aim is to become the Superman or hyperanthropos, a man who has overcome man.

‘The Superman is the meaning of the earth’.

‘Uncanny is human existence and still without meaning...I want to teach men the meaning of their existence: which is the Superman, the lightning from the dark cloud man’. (Nietzsche, 1961, p. 42, 49).

In the notion of *eternal recurrence* Nietzsche obtains immortality in a form that provides quality, a moral law and purpose: striving to live life so that we wish to live it over and over again. In both his doctrines Nietzsche is seeking '*to minimize the importance of ends, of purposes and of actions and maximize the importance of states of being*' (Hollingdale, 1961). Since every moment is repeated infinitely, then every moment is of significant importance. Nietzsche encourages humans to progress in life but not in order to *do* but *become*. It seems as though Nietzsche urges people to live life fully and die tired. However, wishing for an eternal recurrence of one's life is extremely difficult if not impossible.

Nietzsche also believed that life evidences a *will to power* and urged the acceptance of it. *Will to Power* is a foundational theory of what it means to be human. He explains all actions and codes of moral law as expressions of this drive. For him hopes for a higher state of being after death are explained as compensations for failures in this life. According to Nietzsche people should sublimate their will to power in order to become a new and ultimate form of human life, the superman (van Deurzen & Kenward, 2005).

Human beings need meaning and purpose in their lives under all circumstances and to live without it provokes considerable distress. Meaninglessness is often connected to absurdity as it implies chaos, disorganisation, and pointlessness. The realisation of our mortality and futility following diagnosis of an illness could lead to a sense of meaninglessness. In a severe form, meaninglessness can paradoxically lead to the decision to end one's life. Consequently, human beings are '*condemned*' to create meaning in their lives and this is one of the aims of existential therapy (Yalom, 1980).

Binswanger was the most significant figure in existential practice as he was the first to demonstrate application of philosophical concepts to psychiatric practice and the effectiveness of that method (van Deurzen, 1997). Binswanger through Heidegger's concept of '*being-in-the-world*' regarded his patients in terms of 'the *how* of being-in-the-world and the attitude *toward* world' (Binswanger, 1994, p. 195). Ultimately, the uniqueness of existential psychology lies on this concept of *ontology*, the study of *being*, of existence.

Cancer prevalence, mortality and survival rates

Cancer was in 2010 the second leading cause of death, accounting for the 28% of deaths in the European Union. Mortality rates among men are twice as high as those for women. This is due to the greater prevalence of risk factors existing among men and the limited availability of screening programmes for the types of cancers affecting men. This leads to a lower survival rate following diagnosis (OECD, 2012). In 2002, there were an estimated 3.45 million new cancer cases and 1.75 million deaths from cancer in Europe (Ferlay et al, 2013).

The four most common cancer sites representing half (50.5%) of the overall cancer diagnoses are: cancers of the female breast (464,000 cases, 13.5% of all cancers), followed by colorectal cancer (447,000, 13%), prostate (417,000, 12.1%) and lung cancer (410,000, 11.9%). The most common causes of death from cancer are cancers of the lung (353,000 deaths), colorectal (215,000), breast (131,000) and stomach (107,000) (Ferlay et al, 2013).

Breast cancer is the most common type of cancer among women and is accounted for the 30% of cancer incidence deaths in 2008 and 18% in 2010. Over the past decade there has been an increase in the incidence rates of breast cancer and annual incidence in Europe is expected to rise to 466.000 cases by 2020. However, death rates have declined or remained the same, which inclines a rise in survival rates, due to the earlier diagnosis and better treatment. Survival rates reflect advances in public awareness, screening

programmes and developments in treatments and the combination of those such as breast conserving surgery and radiation (OECD, 2012).

Furthermore, prostate cancer is the most common cancer among men and in particular those over the age of 65. However, death rates for lung cancer are higher than those for prostate. It is likely that the rise in incidents for prostate cancer is due to the greater use of prostate-specific antigen (PSA) diagnostic tests. Since 1995, death rates have declined in most EU countries OECD (2012) and in addition survival rates have improved for all cancers.

Since 1990s the European Community sponsored EUROCare (European cancer registry-based study of cancer patients' survival and care), in an attempt to comparatively analyse survival data from European population-based cancer registries. The first results came out in 1995 with EUROCare-1 on 30 cancer registry populations from 12 countries showing significant differences between countries, in cancer survival. In particular, low rates in eastern European populations, intermediate rates in Denmark and the U.K. and high rates in other western European populations (Berrino et al, 2009).

According to EUROCare-4 which includes cases diagnosed up to 1999, survival rates for patients treated in 2000-2002 were at the highest for countries in northern Europe and lowest in countries in Eastern Europe. However, there seems to be an improvement in survival rates. An interesting observation is the difference in survival rates within-countries. In particular, in the north, the wealthier part of Italy, survival is better than the poorer south. Similarly, in the U.K. cancer survival is lower in socially deprived areas

(Berrino et al, 2009). A new addition to the EUROCare includes extensive estimates of the proportions of patients that have been cured of their illness. In particular, EUROCare presents a 5-year relative survival which is perceived as approximating to the probability of being cured by cancer.

Overall, there is significant variability in incidence and mortality rates among European countries and a number of issues need to be considered before drawing any conclusions. Depending on each country's health care system, screening programmes vary and consequently so do incidence rates. Cancer mortality rates are also prone to a lower accuracy (validity) due to the difficulties in ascertaining and certifying the cause of death (Ferlay et al, 2013). *'For example, breast cancer survival has been reported as being significantly higher in the US than in Europe. However, a comparative study found that differences in age, stage at diagnosis, and number of lymph nodes evaluated explained most of the excess risk of European patients indicating that the problem is later diagnosis rather than less effective treatments'* (Berrino et al, 2009, p. 905).

From Existential Philosophy to Clinical Practice

There are numerous textbooks offering a clear and concise account of the existential-phenomenological approach to psychotherapy such as Mick Cooper's *Existential Therapies* (2003); Ernesto Spinelli's *The Interpreted world* (2005) and *Tales of Unknown* (1997); van Deurzen's *Everyday Mysteries* (1997) and *Existential perspectives on human issues* (2005).

A research by Wilkes and Milton (2006) explored the experiences of existential therapists in relation to their practice and to issues like dialogue, relationship, process and use of underlying philosophies. Following the position that every therapist's style is unique, and consequently the nature and aims of therapy are inevitably individualised, this research is also looking for the participants' personal understanding of the approach and its application.

Feelings arising following a cancer diagnosis

A cancer diagnosis followed by a series of treatments is a painful and life changing experience. Several studies have identified the feelings arising in adults following a cancer diagnosis. Straker (1998) writes that the realisation of one's mortality and the possibility of death can cause feelings of anxiety, depression, despair, hopelessness and meaninglessness. In addition, the physiological effects of certain treatments, concerns about disruptions in life plans, diminished quality of life, and disease recurrence or progression can be some of the triggers of those feelings (Jacobsen and Jim, 2008; Stark

and House, 2000). Even though studies identify the existence of depressive or anxiety feelings, (Hotopf, Chidgey, Addington-Hall, and Lan, 2002; Williams and Dale, 2006; Sharpe et al, 2004) measure and propose guidelines for their management, they fail to look at what those feelings are all about, what lies underneath them and what meaning they have for the individual.

Furthermore, different stages of the illness can cause different reactions to the individual. The first phase of cancer, the diagnosis, could come as a shock and bring disbelief, anxiety, guilt and bitterness and also the hope that the initial treatment will be successful. Patients who have devoted their lives to a healthy lifestyle might see a cancer diagnosis as a major affront. Some patients might require a psychotherapeutic intervention at this stage when they feel overwhelmed by the fear of death, the threat of loss of power or existential anxiety over the meaning of their life. Several important factors in a person's life can be affected following a cancer diagnosis and aspects of everyday life might be subject to change or disruption. The following could possibly arise as themes during the therapeutic encounter: The person might have to reconsider his/her lifestyle, accept the need to depend on others, lose his/her autonomy, come to terms with unaccomplished life goals and re-evaluate relationships with others and at the same time mourn for his/her lost health. However, the different phases of cancer can evoke different feelings and reactions (Straker, 1998). Feelings of hope, before the initial treatment, might disappear afterwards and be replaced by despair, anger and lack of trust. In addition to feelings of depression, other issues, linked to the reality of human existence such as anxiety, loss of meaning, the realization of one's mortality and temporality might come to light following a diagnosis of cancer.

Psychological interventions for clients with cancer

Over the years several psychotherapeutic interventions including psychiatric (Massie, 2005), psychosocial (Meyer and Mark, 1995; Spiegel, Bloom, Kraemer and Gottheil, 1989; Uitterhoeve, Vernooy, Litjens, et al., 2004) and psychological (Edwards, Hulbert-Williams and Neal, 2008) have been researched in relation to their application to cancer patients. Psychiatric consultation and psychotherapeutic support have been proven to be beneficial for clients with cancer and in particular women with breast cancer. It is believed that therapy provides the opportunity to address existential, emotional, psychosexual and relationship issues, express concerns, manage fear and anxiety and gain support (Massie, 2005). Furthermore, psychological interventions regardless of whether they aim to facilitate adjustment to the illness or treat psychological problems have been proven effective to improving emotional well-being. In particular, in a number of clinical control trials a better psychological outcome was evident for patients who received psychological treatment and additionally improvements were observed in their medical condition and length of survival (Massie, 2005).

Different psychotherapeutic approaches such as psychodynamic and cognitive behavioural have been applied to this particular client group. In addition, research has looked into group (Spiegel, Morrow, Classen, Raubertas, Stott, Mudaliar, et al., 1999) as well as individual therapeutic work. In order to get an understanding of the richness of psychotherapeutic interventions to cancer, a presentation of the research findings for each of the most common psychotherapeutic interventions will be presented below.

Straker (1997) suggests that psychodynamic psychotherapy is particularly useful for patients diagnosed with cancer for understanding their emotional reactions to cancer and clarifying the onset of their psychiatric symptoms in response to their diagnosis.

The therapist working with cancer patients can find himself being a '*container*' for the patient's anxiety. As with any case, working from a psychoanalytic perspective entails receiving transference projections that can lead to strong and intense counter-transference reactions. However, working with cancer has additional elements. For a start, the therapist will be faced with the question of his own mortality, especially if the client is of similar age or life situation that the therapist can identify with (Parkinson, 2003). Furthermore, there is no doubt that the therapist's personal history, attitudes towards death and loss will contribute to his ability to work with people who are ill or dying (Wallbank, 1997).

Group work

Group psychotherapy has been used for clients with a wide range of emotional as well as physical difficulties. Fobair's (1998) articles provide a comprehensive account of group therapies and cancer support groups. Extensive research has been produced observing the effectiveness of psychotherapeutic intervention to clients with cancer. Empirical evidence suggests that group psychotherapy is effective in ameliorating psychological distress and in some cases improving survival (Blake-Mortimer et al., 1999).

Spiegel, Bloom and Yalom (1981) studied the effects of group support for women with metastatic breast cancers in a one-year, randomized, prospective outcome study. The group's focus was the issues arising from a terminal illness, improvement of relationships and living as fully as possible. The researchers hypothesised that this could assist to mood improvement of participants, developing coping strategies and enhancing self-esteem. Significantly lower mood-disturbance and fewer maladaptive coping responses were showed by the treatment group, who were also less phobic (Spiegel et al., 1981). In a subsequent study by Spiegel, Butler, Giese-Davis, Koopman, Miller, DiMiceli, (2007) findings claim that longer survival was associated with supportive-expressive group therapy were not replicated.

A systematic review of the literature by Edwards, Hulbert-Williams & Neal (2008) concludes that any benefits from the interventions are evident for some of the psychological outcomes and only short-term. However, a question arising here is whether living better actually means living longer and vice versa.

Alternatively, a research by Ferlic et al. (1979) showed that group counselling resulted in significant improvement in patients' perception and self-concept. Several aspects of life can be affected and several feelings may arise such as fear of isolation, fear of suffering, fear of death, feelings of being a burden, thinking of self as less of a person than before, family, sexuality and health are common and all aspects of life that may be affected by a cancer diagnosis. Following group counselling patients reported greater comfort about being part of the hospital system and greater confidence in their relationships with the medical staff in the midst of a potentially negative experience. They also developed a better understanding of the various aspects of cancer and were more at ease with their reactions to death (Ferlic et al., 1979).

Other types of groups include psycho-educational groups where each meeting is devoted to a specific issue such as a medical problem, or a lifestyle issue or a psychological concern. The facilitator provides relevant information and there is also space for discussion.

Since the 1980's Cognitive Behavioural Therapy (CBT) was considered an appropriate approach for working with the issues of anxiety and depression that cancer patients were faced with (Moorey & Greer, 1989). A study by Greer in the 70's showed that powerful patterns of coping can assist with preserving the purpose and meaning in a patient's life even during the most difficult phases of the illness, whereas other types of patterns can lead to avoidance, helplessness and anxiety. Moorey and Greer (1989) proposed *Adjuvant Psychological Therapy* (APT), a type of psychotherapeutic intervention for cancer patients based on Beck's cognitive therapy (Beck et al., 1985). This model primarily focuses on the individual's perception of the threat that cancer entails and the strategies adopted by the patient in order to cope with that threat. The emotional distress the patient experiences will be mediated by his interpretations upon cancer and its treatment. The emotional support received from relatives and friends has a significant part on the patient's perception of the consequences of his illness and his ability to cope with it. Consequently, there seems to be an on-going interaction between objective effect of the disease and the thoughts and behaviours of the patient. *'Adjustment to cancer seems to be the ability to experience and express the emotional as well as the purely cognitive impact of the disease'* (Moorey & Greer, 1989, p. 178). Unlike less structured approaches, APT is a problem-solving approach, assisting with building coping skills and aims at motivating and empowering the patient in order to fight the disease. Open expression of feelings is encouraged and attempts are made to improve communication with relatives.

Barraclough (1999) presents a few issues clients diagnosed with cancer often face and CBT could assist with:

- Reluctance to look at a mastectomy scar or change a colostomy bag
- Nausea in anticipation of chemotherapy
- Fear of being alone under a radiotherapy machine
- Reluctance to go out because strangers seem to be staring
- Pain that gets worse in certain emotional situations
- Excessive bodily checking for signs of recurrent cancer

Yalom (1998) claims that effective cancer counselling is based on the four existential concerns of death, freedom, isolation and meaninglessness. On several occasions, clients diagnosed with cancer can lose meaning in their lives; experience feelings of despair and futility. Consequently, a cancer diagnosis can be an opportunity for change and review. One of Yalom's clients expresses his regrets by saying '*What a pity I had to wait till now, till my body was riddled with cancer, to learn how to live*' (Yalom, 2008, p.34). He also claims that a large number of cancer patients use their crisis as an opportunity for change and personal growth by rearranging priorities, adopting an enhanced sense of living in the present, developing deeper communication with loved ones. Confrontation with death could therefore lead to a positive personal change (Yalom, 1980).

Working with cancer from an existential vantage point

It becomes apparent from what has been already discussed, that the feelings arising for individuals following a cancer diagnosis as well as the themes emerging in therapy, are very existential in nature. A presentation of the main theoretical ideas of existentialism in relation to cancer will follow.

It is a fact of the human condition that human beings are living towards death. However, in everyday life humans tend to forget the temporary nature of their existence. A cancer diagnosis can serve as an awakening experience and bring people face to face with a reminder of their finite nature.

On occasions, philosophical ideas and insights on death can be useful contributions to psychological models. There is a mutual agreement between philosophical theories and psychological ones that there is a need for human beings to '*integrate and make sense of death*' and their views and feelings towards it (Tomer, 1994, p. 4).

For Heidegger '*Death is something that stands before us – something impending*' (Heidegger, 1962, p. 294). Clinical work with clients that have been diagnosed with cancer cannot therefore exclude the subject of death as well as the feelings accompanying that realisation. Furthermore, temporality according to Heidegger is at the heart of what it means to exist. Our understanding of the present comes always in relation to the past and projection to the future. The ultimate limit however to our

existence is death. Our being is therefore always subject to an awareness of our finite nature and the end of our possibilities.

The ontological limits of our existence and the fact that we have no control over the cease of our existence can create angst or anxiety (Langdridge, 2008). *'The 'end' of Being-in-the-world is death'* (Heidegger, 1962, p. 276). The *'End'* according to Heidegger limits and determines whatever totality is possible for Dasein. Heidegger uses the word *'Dasein'* to refer to human being, literally meaning *'being there'*.

For Heidegger death is on the one hand a threat of non-existence and at the same time a realisation of our potential non-existence. It is a precondition for a fuller life and liberates us from anxiety. Heidegger argued that the awareness of our death can shift us from one state of being to another, from an inauthentic state of being to an authentic one. When living authentically one can become fully self-aware, embrace his possibilities and limitations, face absolute freedom and nothingness and the inevitable anxiety.

There is no better portrayal of life's pain, struggle, and futility than the philosophical essay *'The Myth of Sisyphus'* by Albert Camus. In this essay, Camus argues that human beings can construct a new life meaning by cherishing our *'nights of despair'* by facing meaninglessness and arriving at a posture of heroic nihilism. As the essay concludes *'The struggle itself...is enough to fill a man's heart. One must imagine Sisyphus happy'*. (Camus, 1955, p. 111). Humans are therefore encouraged to live the struggle in life and hence create meaning out of it in order to have a worthwhile life.

As mentioned above, working with cancer involves arising issues of death fear and anxiety, futility and meaninglessness. The terms '*fear of death*' and '*death anxiety*' are widely used within the existential approach to therapy as well as within cancer and palliative care settings. Wong et al. (1994) suggest a distinction where *fear of death* is regarded as specific and conscious whereas *death anxiety* can be generalized and non-accessible to awareness. Wong (1994) argues that the absence of fear of death may reflect denial of death. There are different reasons that cause fear of death such as the unknown, the loss of self and all possibilities, pain and suffering, atonement and salvation and welfare of surviving relatives. Furthermore, another source of fear for people could be the realisation of ones finite nature as well as the realisation of not having lived a meaningful life. From an existential stance '*the fear of death plays a major role in our internal experience as it haunts us*' (Yalom, 1998, p. 183). In order to cope with that fear individuals develop defences, based on denial that protects them from death awareness. More importantly, people's attitudes towards death, shape the way they live and grow as well as the way they respond to illness and health. Death is a fact of life, '*life's most self-evident truth*' and a primordial source of anxiety. However, Stoics also describe death as '*the most important event in life*' claiming that '*learning to live well is learning to die well*' and vice versa. Drawing from other great existential thinkers Yalom claims that '*Although the physicality of death destroys man, the idea of death saves him*' (Yalom, 1998, p. 185), an attitude that lies at the core of existential philosophy and psychology.

Goldie & Desmarais (2005) have proposed that psychotherapeutic interventions and especially talking and listening to clients with cancer may in some cases enable them to

achieve a philosophical acceptance of their own life and its possible termination by cancer. The client with a limited lifespan through the process of psychotherapy may acquire meaning in life that he/she never had before. Often psychotherapy focuses on psychopathology. However, a different approach that focuses on what has been blocking the client's full expression as well as his/her strengths and positive qualities can lead to valuing and accepting one's self, his universe and fate (LeShan & LeShan, 2002).

In his studies Fife (1994) explored people's conceptualisation of their illness. He defined meaning as the perceived nature of the relationship between the person and his world that is developed within the context of specific events. He identified two inextricable dimensions the meaning related to the person's identity and how it is affected by the illness, and the meaning related to characteristics of the event and the social circumstances that followed. Subsequently, a study in 1995 on 422 cancer patients showed that meaning was found to be predicted by social support and specific coping strategies, personal sense of control, body image and psychological adjustment (Fife, 1995). Consequently, the more support the person received, either from the family environment or from professionals, the more positive was the meaning of their illness. Fobair (1998) suggests that the therapist should encourage clients or group members to reconsider their old beliefs that are no longer helpful and discover the meaning of their illness in their lives.

Breitbart & Applebaum (2011) introduced Meaning-Centred Psychotherapy (MCP) an approach arising from the need to acknowledge *'despair, hopelessness and desire for hastened death in advanced cancer patients who were, in fact, not suffering from a*

clinical depression, but rather confronting an existential crisis of loss of meaning, value and purpose in the face of a terminal prognosis' (Breitbart & Applebaum, 2011, p.137).

The speciality of the existential-phenomenological approach is its intersubjective and interactional view of the human existence as opposed to the individualism of other therapeutic approaches. The phenomenological therapist would therefore approach a client with cancer with the same openness he/she would approach any other client and with no presumption of what would take place in the therapeutic encounter.

An awakening experience, as the one described by Yalom's client above, could lead to significant change in one's life. People may reconsider their life-style; begin taking stock of their lives and aim for a fuller living. Tomer (1994) writes that a psychological model, such as the existential-phenomenological, could try to understand whether death is perceived as a threat to existence or as a condition of meaning. Through his work with cancer clients Yalom (2008) shows that most of them rather than being numbed and immobilised '*they were positively and dramatically transformed*' (Yalom, 2008, p.34). Clients reviewed their priorities in life, chose not to do things they didn't wish to do, began communicating deeply with relatives and loved ones and appreciated things that are often neglected such as seasons changing, nature and holidays. Yalom (2008) adds that many clients reported greater willingness to take risks, a diminishment of their fears of others and less concern about being rejected. Death can provide the condition, the 'urgent experience' for an individual to move to a state of mindfulness. '*Death is the condition that makes it possible for us to live life in an authentic fashion*' (Yalom, 1998,

p. 187). Yalom (2008) concludes that the idea of death can save us as it can force us into authentic life modes, enhancing our pleasure in living a more fully life.

Human beings are usually drawn into their everydayness, living in an ontic mode. It usually takes a crisis or irreversible experience such as a cancer diagnosis in order to become mindful of being and awake out of the everydayness into an ontological mode of being. There are numerous near death experiences that lead to more meaningful lives afterwards. Research by Russell Noyes as cited in Yalom, (1998) showed that 23% of two hundred people who had near death experiences reported: a *'reassessment of their priorities'* in life, becoming more empathetic, acquiring *'a strong sense of the shortness of life and the preciousness of it...a greater sense of zest in life... an ability to live in the moment... a greater awareness of life-awareness of life and living things and the urge to enjoy it now before it is too late'* (Yalom, 1998, p. 190).

Based on philosophy, the existential approach takes the stance that individual's awareness of death, mortality, their weaknesses and limitations is as important as the awareness of their possibilities and strengths. Most of the time in life, people are not aware of their mortality. In several cases people may chose not to think or talk about it and even deny it. The question that then arises is *'what happens when we don't have a choice in the matter and we are confronted with our mortality by force?'* Individuals encounter death in different ways and existential therapy allows space for the exploration of those views (Barnett, 2008).

This study will therefore look at how the therapist encounters the possibility of the client's death. Existential philosophy attends to the issue of death because it can '*reveal authentic possibilities of human existence*' (Cooper, 1999, p.133). However, what is central to existential approach in therapy is the personal human response to death, rather than an empirical, third-person analysis of death as an event that can be objectively scrutinised.

Existential practice views human beings as embodied and embedded within history and culture. Furthermore, it places great attention to the finite character of existence. Existential therapy therefore considers the individual in the context of his whole lifespan. The inevitability of death from an existential vantage point is seen as a *possibility* (Heidegger, 1962) rather than limitation; it '*forces*' as to take a stance in life and live our lives deliberately. This view is invaluable to the existential/phenomenological therapeutic practice as it empowers clients to attend to human limitations and work with the tensions they evoke.

Existential counselling psychology can offer the opportunity to look at one's present, review the past, and attend to future (no matter how limited) so that clients can begin to take stock of their lives and embrace the imminence of their death. Working from an existential vantage point allows attention to all dimensions in living and also focus upon the creation of (new) meaning within the givens/limitations of the clients' context. However, how does all that affect the therapist?

Implications for practitioners working with cancer and in palliative care settings

Significant number of studies has explored the experiences of practitioners working within palliative care and with cancer patients such as nurses, psycho-oncologists, and medical staff. The main findings of studies will be presented below as it is believed to provide insightful information for psychotherapists too.

Extensive research has explored the experiences of nurses working in palliative care. Psychosocial aspects of care have been reported to have personal as well as professional impact upon nurses. Work in palliative care and emotional interactions can influence nurses' wellbeing but can also be a source of job satisfaction. In particular, emotional challenges have been identified on nurses working with patients with life-limiting illness such as cancer (Rose & Glass, 2009).

A study exploring nurses' experience of working in palliative care settings has identified five ways of their conceptualisation of their work: doing everything they can; developing closeness; working as a team; creating meaning about life; and taking care of themselves. Work in palliative care is without doubt a demanding and stressful context for nurses especially as patients '*seek to share their fears, hopes and expectations with nurses...placing upon the receptive nurses many emotional and physical demands*' (Barnard, Hollingum, & Hartfiel, 2006, p. 6).

Psychosocial care and emotional support offered by nurses in palliative care has been identified as challenging, impacting upon their wellbeing as workplace environments often are not conducive to promoting emotional health causing nurses feeling inadequately supported. In addition, nurses claimed feeling unheard as they did not always have the opportunity to discuss their emotional wellbeing with colleagues even though they had the need to do so (Rose & Glass, 2009).

Stress and burnout are two issues often faced by medical professionals. Stress is inevitable in the practice of medicine. Delivering bad news, providing palliative or terminal care, dealing with client suffering and death are some of the stressors often encountered by medical professionals. Burnout can occur from an imbalance between the demands of a job and the person's ability to cope. It can involve emotional exhaustion, depression, low self-achievement, loss of interest and enthusiasm in the job. Early signs include fatigue irritability, poor concentration and physical symptoms such as headaches and backaches. An individual progressing to a more serious, chronic problem can experience boredom and cynicism. The other polarity could involve a full dedication to the job, pushing personal limits to exhaustion and neglecting personal life (Penson, Dignan, Canellos et al., 2000).

In a study conducted by Canellos as stated in Penson et al. (2000) a questionnaire was sent to one thousand subscribers of the *Journal of Clinical Oncology*. Fifty six per cent of the six hundred and sixty respondents claimed to be burned out. A sense of failure, frustration, depression and loss of interest in their practice were some of the issues respondents presented. It is important to be noted that half of respondents believed this

problem to be inherent in their work and eighty five per cent claimed it was affecting their personal and social life.

Barraclough (1999) suggests the following action points in order to prevent burnout in health care professionals: Work conditions (refrain from working excessive hours and having heavy workload), informal staff discussions to release tension, formal staff support through sharing, group and individual counselling or psycho-education for anxiety management, and encouraging self-care.

Having explored the implications this kind of work has for medical staff a review of the current literature on the impact of this work upon the psychologist or psychotherapist will follow.

Practitioners working in settings such as the ones presented above are often faced with physical deterioration and death. It is not uncommon for therapists to avoid working with clients facing terminal illness such as cancer. As Yalom (2008) explains therapists that are reluctant to face their own death anxiety would avoid working with this group of clients. He beautifully presents the impossibility for human beings to be constantly aware of their mortality. It is like staring at the sun, we can only do so much of it. For therapists working from an existential-phenomenological approach it could be assumed that they would be willing to address those issues with their clients and dare exploring them since embracing the inevitability of death is the core of the approach's philosophical underpinnings. In similar lines Wallbank (1997) states that the therapist's

ability to work with ill or dying people depends on their personal history and attitudes towards death.

There are several implications for the counselling psychologist working with clients diagnosed with cancer; emotional as well as practical. A review of the current literature and research on the subject will be provided below.

Unpacking the experience of offering therapy to clients with cancer

There are a number of textbooks and writings (Lederberg & Holland, 2011; Postone, 1998; Faulkner & Maguire, 1994) focussing on psychotherapy with clients with cancer. Postone (1998) highlights a significant distinction that exists in the issues involved in therapy with patients diagnosed with cancer and patients with psychosomatic disorders. More specifically, psychotherapy with cancer patients involves working with the emotional impact of suffering from a life-threatening illness. Psychotherapy with patients with psychosomatic disorders focuses on the somatic expression of psychological distress whereas the latter on the psychological experience of an individual with a somatic illness. The two therapeutic practices will share many commonalities such as the kinds of intrapsychic conflicts however it is the focus of psychotherapy that will be different (Parkinson, 2003).

Parkinson (2003) states that therapists working with people diagnosed with cancer could be regularly confronted '*with a high level of raw emotion*' (Parkinson, 2003, p. 422).

Feelings of sadness, anger, fear, grief may be evoked for the therapist and also feelings of guilt for being well and healthy (Wallbank, 1997).

In their chapter in the *Handbook of Psychotherapy for cancer care*, Lederberg and Holland (2011) present several skills and ideas that could be incorporated in the work of counselling psychologists from different theoretical orientations when working with clients with cancer. A very important point stressed by the authors is the need for practitioners to know cancer as a medical illness. For example, being able to understand medical information, being aware of the biological aspects of the illness such as the different stages of the illness, its progress, the treatment procedures and side effects of those as well as having the flexibility to recognise and meet the patients' changing psychological needs. Lederberg & Holland (2011, p.3) propose '*supportive psychotherapy*' as an intervention aiming to help patients deal with distressing emotions, reinforce their pre-existing strengths and encourage coping with the illness.

The practitioner who engages in such kind of practice ought to be able to clarify and openly discuss highly charged information, manage the emotions that arise constructively, be familiar and comfortable with the use of other techniques. For example, cognitive-behavioural therapy facilitates problem-solving and learning, crisis intervention as well as willingness to explore dynamic patterns of the patient. In addition, co-operation, support and guidance might be required for family members or caregivers of the patient. Lastly, the importance of understanding one's own emotional responses is pointed out especially during early days of practice while developing the ability to manage oneself in those demanding situations. Lederberg & Holland (2011)

recognise the difficulty of psycho-oncologists working exclusively with cancer patients. For that reason, they emphasise the importance of self-monitoring for example keeping in mind one's limitations and having awareness of the counter-transference reactions due to the exposure on *'wrenching human tragedies and death, the latter always hovering in the thoughts of both patient and therapist'* (Lederberg & Holland, 2011, p.12).

Authors also highlight the need for practitioners to review losses in their lives and understand their motives for this kind of work. That is not to say that personal experiences or losses can obstruct the work but rather can be used constructively. *'Many of us, not all, come because of personal losses or ordeals. They need not disqualify us, but we must be aware of them and how they might affect us therapists'* (Lederberg & Holland, 2011, p.13). In addition, practitioners should be attentive of over-involvement and over-identification. *'We must learn to be involved enough to be authentic with patients, but not so involved that we let them invade our personal life more than rarely'* (Lederberg & Holland, 2011, p.13).

Death in the therapy room

As the therapeutic work is never one-sided, when death enters the therapeutic space it will inevitably influence both the therapist and the client. Death can suddenly appear in therapy through several life events such as the loss of a family member, a friend, a natural disaster, or a diagnosis of a life-threatening illness (Barnett, 2009).

Therapists are required to work with the aforementioned issues under difficult and unusual conditions and face the possibility or the unexpected death of their clients. There is no question that this kind of work has a great emotional impact upon the practitioner. Lockett (2009) places great emphasis on the therapists' willingness and courage to explore their own feelings and fears around those existential issues. She claims that therapists who are open, fearless and committed to explore their existential concerns and motives for doing this work may develop a more genuine presence with clients affected by cancer.

Different stages of cancer can evoke different issues; for instance the shock of a diagnosis and the process of accepting a terminal condition. Looking at terminal stages Culkin (2002) suggests that different illnesses create unique medical, psychological, and social problems for patients. In particular, terminal cancer is characterised by a prolonged course, periods of remission and stigma. Cancer can be progressively a debilitating illness causing a painful struggle for the patient in addition to the aversive medical treatments. While working with those issues therapists can use several techniques such as stress and pain management, in order to enable clients go through the

treatment process. Relaxation, desensitization and other behavioural techniques can be helpful for cancer patients in order to learn to control the anticipatory stress and nausea related to chemotherapy (Culkin, 2002). Prior to the use of techniques, clients need a caring environment where their needs can be met, where they don't feel a burden and where their individuality and integrity can be maintained. They need to be given the opportunity to voice their fears, come to terms with their illness and their condition. Thus, therapy should try and offer a safe and trustworthy environment to work with those issues (Williams, 2001).

As mentioned above, there is a high possibility of losing a client in this context of practice. The vast majority of literature on therapists' responses to client death is in the realm of therapists' reactions to client suicide. Hardly any studies exist looking at therapists' emotions on client death from other causes and cancer in particular. Therapists' responses are grouped into emotional (personal) and professional (related to their practice).

The therapeutic relationship is a strong bond and therapists often care deeply about their clients. Losing a client is therefore as difficult as losing a loved one. Veilleux (2001) quotes several case studies (Fox and Cooper, 1998; Rubel, 2004) that reflect the feelings of pain, loss, and isolation that therapists may feel when clients die unexpectedly. She also cites two unpublished doctoral dissertations (Ford, 2009; Schwartz, 2004) that have examined the impact of non-suicidal deaths upon therapists. Both studies reported the strong emotions of therapists to hearing about the client's death, *'including shock, disbelief, anger, sadness, and relief'* (Veilleux, 2001, p. 223). Those studies also showed

participants' feelings of denial, pressure and struggle with the mourning process as well as uncertainty regarding encounter with the bereaving family members. A very important observation from Ford (2009) is that participants described a lasting impact on their lives; both personal and professional, even when contact with the client had been minimal (Ford, 2009).

Research has shown that therapists working with dying clients encounter personal stresses; emotional, physical and intellectual repercussions that often go unrecognised. That kind of work is considered of great importance for both client and practitioner as it touches upon the human condition shared by both; it can therefore be very challenging and very rewarding at the same time (Martin & Berchulc, 1988).

Another aspect of human existence for Heidegger is that we are beings-in-the-world and always in relation to others (Heidegger, 1962). The only moment in life where it might seem we are alone is death. However, even then, our death and its probability influence people around us. Similarly, it influences the therapist working with the cancer client. Existential thinking can thus help inform the engagement with patients and relatives who are grappling with life and death issues where the ordinary fabric of their lives has been torn apart (Hazzard & Henderson, 2004).

Lockett (2009) adds that therapists working with cancer clients need to explore their own issues around death and dying as well as their existential anxieties in order to work more effectively. In addition, facing and accepting their finite nature people can be free to live a less fearful life and only then can a therapist meet those facing the threat of a

shortened life. Therefore, therapists need to be prepared to listen to the deep existential anxieties and issues around dying. Steel beautifully illustrates the therapist's response and emotions on realising that a client has passed away:

'When I heard of your death first of all, I was shocked. It was the middle of August. I had just come back from my summer holiday, I turned on my computer, and it was the first email I saw. I opened it. And my heart jumped into my mouth, Mina. It told me you had died the week before. Yet I carried on with my day, much as usual. I saw my patients, attended meetings; I even ate my lunch, in front of my computer screen, as I was accustomed to do. But deep down inside of me something had locked. The day passed. I went home in the evening at the usual time. I went to bed. Then, I remember, I woke suddenly in the night, I was sweating, and my heart was beating fast. That's when the freefall started. After that, I didn't see any further patients for a month. In fact, for weeks, I barely left my house' (Steel, 2010, p. 5-6).

The therapeutic relationship is a very close one for both the therapist and the client. Losing a client and being with them near death or while they are going through a life threatening illness and a painful treatment cannot leave the therapist unhurt.

Besides the emotional impact that such a work has on therapists there are several differences in the practice comparing to other client groups or other work settings. Those deviations will be described below in order to provide an understanding of the implications in work with clients diagnosed with cancer and offering therapy within a hospital environment.

For Culkin (2002) labelling a person as '*dying client*' locates him in a special category and creates several emotional, social, spiritual changes in the climate of therapy. The client is seen as being in a critical state, with little time remaining, or no hope of

recovering. As a consequence to this unique existential position there is a need for adaptations of the typical psychotherapeutic attitudes and strategies. For instance the goals, structure, frame and process of therapy must meet the clients' needs and circumstances. Work with clients diagnosed with cancer usually takes place within a hospital environment. This element adds to the differences described below between therapy with clients with cancer and other client groups.

A different therapeutic frame

Madison (2004) proposes some common deviations from the usual therapeutic frame that a therapist working in a hospital setting can come across are:

1. *Inconsistency of place.* Since many patients are physically unable to leave the ward or even their bed sessions might take place in patients' bedsides, rooms, wards and often the same place may not be available twice.

2. *Inconsistency of session timings.* Often a regular time allocated for a client might be interrupted by medical staff wishing to perform examinations which are very difficult to reschedule.

3. *Inconsistency of frequency of sessions and contact durations.* Meeting the clients once a week on a specific day and time may not be possible under those circumstances. Frequency of sessions has to be flexible considering that the client might be discharged or even dead by the next regular session. The client can be seen once a week, daily, or sporadically upon request. Similarly, duration of contact is not always clear as it can change from short-term to long-term or crisis work. Therapists might thus find themselves embarking on a contract without always knowing what they are agreeing to. Also often therapy can be terminated abruptly due to unexpected discharge, hospital transfer or death.

4. *Inconsistency of session duration.* The patient's physical condition and energy levels can lead to requests for shorter sessions. However, the opposite might also be possible when a client is in a crisis and needs support for a longer period of time.

5. *Interruptions.* When working in hospital settings interruptions are almost inevitable. All space is considered fairly public and staff can interrupt a session for various reasons. Often other professionals don't fully appreciate the importance of not disturbing the session.

6. *Intimacy/distance and physical touch are challenged.*

Attending sessions at the client's bedside also introduces an element of intimacy unusual in conventional therapy. Therapists may be in a situation in which touch is requested for example, assisting their clients into wheelchairs, help to position them in bed. Also, the fact that the therapist may go to the client rather than the opposite, makes it difficult for the client not to attend a session.

7. *Confidentiality and anonymity of the client cannot be guaranteed.* Family members, staff members, other patients, may all know that the client is seeing a therapist. Referrals and session dates for patients must be recorded in their hospital medical notes therefore anonymity cannot be maintained. Sessions that take place in open wards can challenge confidentiality as neighbouring patients and staff can at times overhear sessions.

When working in a hospital setting with medically ill clients, facing death, the frame deviations mentioned above are inevitable. If work is to be done, it requires a more

flexible framework rather than a strict frame. Therapists from all theoretical orientations have to adapt their usual way of working to some extent, when faced with the unique challenges of a medical setting and even more when working with the terminally ill. For example, therapists might have to visit clients on the ward when their illness prevents them from attending a session, and negotiate a different understanding of confidentiality within medical teams (Thomas et. al., 2001).

Existential therapy is about entering the client's world, seeing the world from his window. Yalom (1998) considers the life of a group in a hospital setting to last a single session. The reason being the rapid turnover of group membership, the brief duration of hospitalisation and the changing of the group's composition which dictate a fundamental shift in the therapist's frame. Consequently as much effective work as possible needs to be done in the session as there might not be a chance for another session (Yalom, 1998).

Existential therapists view clients in their context accepting the limitations and givens in their lives. Madison (2004) views the existential-phenomenological approach as one that maintains maximum openness and flexibility. Working phenomenologically encourages the therapist to bracket his/her preconceptions regarding the constituent elements of psychotherapy, such as the frame, boundaries, and '*ground rules*', while simultaneously remaining open to the possibility that all aspects of the therapeutic encounter may be equally revelatory. Consequently, it is assumed that they will more easily adapt to the need for flexibility of this kind of work. Psychoanalysts for instance might have struggled to work in such an inconsistent setting. Spinelli (1994) argues that the therapeutic frame that many approaches propose is a '*Dumbo's feather*'. It gives

therapists something to hold on to. Therefore, therapy can indeed be achieved without having a flexible frame or with one that shifts in order to respond to each particular situation.

Looking at how therapy can support clients with cancer LeShan & LeShan (2002) point out that it is the practitioner's real interest and presence that through human interaction can give meaning to the client. Focusing on life rather than death as they claim can actually diminish the client's fear of death. Time is also an important concept in therapy. Often therapists aim to work with clients into increasing the value of their long term relationships with others and adjusting to their environment. However, when working with cancer clients and clients with limited lifespan, long-term goals are sometimes not realistic (LeShan & LeShan, 2002).

The emergence of the research question

It is probably the researchers' personal interests and curiosity motivating them to conduct a particular research project and further explore an area or subject that they wish to understand better. There is a significant amount of personal intrigue and reward in the engagement with a research project. However, the process of this study has shown to me that there is more to what I initially thought has driven me to this particular topic. There is plenty of room for reflection upon why researchers find something appealing and what makes them decide to dedicate significant amount of energy and time to it.

Upon reflecting on the reasons prompting me to conduct this study, considering I have not been involved with clients diagnosed with cancer in a professional way, it seemed it was all personal. It is not very common for a researcher to conduct a study on something that is not their specialty or professional interest. I believe this topic of study touches me both on a personal level as well as on a professional one.

Facing physical deterioration and pain on others is not something I am comfortable with. Similarly, hospital environments and being close to people suffering is not something I believe I could handle easily. Yet, from a very young age when I decided I wanted to become a psychologist, I valued people who could sit with dying people. I thought this was something that was going to be part of my job and I was very excited. What seemed an incredibly important and attractive work was coloured by doubt and negative feelings. I begun considering working with people suffering from life threatening illness a great challenge and refrained myself from becoming involved in such settings. My choice to conduct this study probably brought up to the surface a question I haven't even realised I had. Is it really that difficult? Or is it as valuable as I initially thought? In an attempt to test myself, come close to that area of work but from a safe distance and in an attempt to find some answers from the people who have been courageous enough to dive deep, I decided to conduct this study.

As it has been presented previously existential practitioners might be open to engage and work with issues like death, mortality, feelings of anxiety or depression as all those issues lie at the core of human existence and existential therapy. However, the question arising here is whether and how is the therapist affected by those issues? What happens

for the therapist when working with a client suffering from cancer who comes to face with his/her mortality? What comes up for the therapist when being faced with the time limitations of the therapeutic encounter as well as the client's existence?

Therapists often feel their task is to help clients towards a long healthy life, set goals, change and project themselves into the future. However, with cancer clients those goals are not always possible. Therapists often avoid working with dying clients for several reasons. The therapist's fear of his/her own hurt seems to be a major factor in the reluctance to work with the dying client. Losing a client can be a painful experience and according to LeShan & LeShan (2002) it is too painful when practice largely or exclusively encompasses of clients with limited life span.

On the other hand, there are several reasons attracting therapists to work with the terminally ill or clients with a life threatening illness. One reason being a drive to understand and make sense of the ultimate limitation in life, death. Kübler-Ross (1991) states that sitting and listening to a person near death sharing whatever they want to share will leave you with *'a good feeling because you may have been the only person who took his words seriously'* (Kübler-Ross, 1991, p. 2). We cannot experience death and we cannot verify it. The only way to try and understand it and make some sense of it is by getting close to people who are dying and allow them to be our teachers (Kübler-Ross, 1991).

Existential therapy can involve a wide range of ideas deriving from a number of thinkers who did or did not call themselves *'existentialists'*. In terms of practice existential

therapy seems to be an attitude rather than a specific set of theories and techniques. This study therefore attempts to shed light to what practitioners consider existential practice.

As the literature presented above suggests, working with mortality, death and dying is at the heart of the existential approach to therapy. A client diagnosed with cancer can experience a storm of feelings and changes occurring to their lives such as loss of their autonomy, realization of their mortality, physical and emotional pain and serious diminution in their quality of life. As research suggests, psychological support can be beneficial in dealing with those issues, anxiety and depression as well as the difficulties arising from treatment procedures. Even though recognition of the impact of cancer upon the client is obvious, its impact upon the therapist is not so.

This study focuses on the existential-phenomenological approach to therapy in particular as the psychological issues arising from such a diagnosis and illness are very existential in nature as it has been previously discussed. In addition, this study was also part of a *Professional doctorate in Existential Counselling Psychology and Psychotherapy*. Finally, it is believed that limited research is available on this approach to therapy and this study aims to contribute to its growth and development.

The Purpose and Aim of the study

The abovementioned questions prompted the decision to conduct a research project that will seek to understand the lived experience of therapists and aspire at informing practitioners working with clients diagnosed with cancer, undergoing treatment or palliative patients. The focus of this study lies on the exploration of the experience of offering therapy to clients suffering from cancer rather than the effectiveness of the psychotherapeutic intervention.

Cancer comes in different stages; the diagnosis, the choice of treatment, the experience of treatments, remission, and metastases and then there might be two paths for the person; becoming a survivor and living as a chronically ill person or losing the fight. Undoubtedly, psychological support can be invaluable for patients at all the different stages and experiences. Most likely the issues that clients would be concerned with at each stage would be significantly different. This study does not focus at a particular stage, for example, at clients who have just been diagnosed and are in a state of shock or focus on clients who are in remission. Rather, an overall exploration of the therapists' experience of being with the cancer client in the therapy room was attempted.

More specifically, the study's aim is to explore the experience of offering existential-phenomenological therapy to clients who have been diagnosed with cancer. An in-depth exploration of existential-phenomenological therapists' lived experiences through a close examination of how they make sense of their experience will therefore be offered.

The Study's Objectives

Through a thorough exploration of the existing literature, it has been revealed that existing research seems to focus mainly on group work as a psychological intervention for cancer patients as well as focusing on one particular type of cancer, usually women with breast cancer. In addition, many studies attend to the effectiveness of therapy, the improvement in the client's quality of life and prolonging survival rather than exploring this life-changing experience (Blake-Mortimer et al. (1999); Ferlic et al. (1979); Jacobsen & Jim (2008). Furthermore, most of those studies do not explore the therapist's experience of working with the cancer client and consequently this study attempts to fill this gap by exploring the therapists' view of individual therapy from an existential-phenomenological stance with clients suffering from cancer. There are as many definitions of existential therapy as there are therapists, participants were initially asked to reflect upon their theoretical understanding and clinical practice prior to being invited to share their experience with their clients.

Research has a significant role in the practice and development of counselling psychology and psychotherapy. McGuire (1999, p. 1) claims that *'Every counsellor is a researcher: for every time we form an understanding of what is going on for a client, and work with that, we are testing out a hypothesis, and altering our activity in the light of evidence'*. At the core of a counselling psychologist's identity lies being a scientist-practitioner therefore, conducting research is highly important and especially research that concerns clinical practice.

Summing up, this study's purpose seems to spread across several personal and professional interests. On a first level, wanting to find out more about this kind of practice aims at satisfying my anxiety and fears and even finding out more about death and dying. In addition, as it will be further explored below this study has significant meaning attached to it and the choice of cancer as an illness was not random. Most importantly however, this study aims at filling in a gap in the literature, the lack of research on the therapists' experiences and therapeutic work with clients with cancer. It is believed that this study would offer valuable information to practitioners of all therapeutic approaches and in particular add to the limited research on the field of existential counselling psychology.

Summing up, the study's objectives are:

- To explore the literature and identify a gap in knowledge which in the future can inform the Existential approach in aiding cancer patients.
- To clarify the context whereby therapists work
- To find and make a research contract with practitioners
- To formulate guidance of value to the profession on ways of working existentially with cancer patients.

Methodology

Quantitative vs Qualitative

Since this study was aiming at exploring a lived experience, a qualitative methodology was used. As Giorgi (1971) emphasises, a research method must occur by attempting to be responsive to a phenomenon so it is not possible for a method to be imposed upon a phenomenon as it would cause great injustice to the phenomenon's integrity (Hycner, 1985).

In contrast to qualitative methodology the quantitative research methods, aim to classify features, count them, and construct statistical analyses in an attempt to explain what is observed. Qualitative methods, aim at a detailed description. There are several differences between the two methodologies in terms of their epistemology, purpose and implementation. Both methodologies are widely used in psychology however; this study will be using a qualitative methodology as mentioned above. Even though qualitative research methods are time consuming, they provide rich materials for analysis leading to a subjective observation of a phenomenon.

Qualitative methods explained

Qualitative research methods such as empirical phenomenology, grounded theory and discourse analysis rely on linguistic rather than numerical data and employ a meaning-based form of analysis rather than a statistical one. More importantly, qualitative methods place emphasis upon understanding phenomena, incorporate open and exploratory questions. In addition, in contrast to quantitative methods, they offer the opportunity for discovering something new rather than proving something that had already been hypothesised (Miles & Gilbert, 2005). Furthermore, qualitative research refrains from predefining a concept of what is being studied and formulating a hypothesis in order to test it. Rather, in qualitative studies the concepts are developed and refined in the process of the research (Kvale, 2007). Qualitative research methods in psychology are concerned with the description and interpretation of phenomena in terms of the meanings these have for the individual. It is intended to approach '*the world out there*' aiming at understanding, describing and sometimes explaining social phenomena through analysing experiences of individuals or groups, interactions and communications or documents (Kvale, 2007). In brief, qualitative approaches seek to unravel how people construct the world around them.

The aim of a scientist varies depending on how science is defined; when viewed from a mainstream psychological perspective, scientists are concerned with rigorous, objective and generalizable knowledge (data). Traditional psychology has adopted a science attitude towards inquiry and taken an authoritative position in relation to applications of its findings and the benefit for others. As argued by Spinelli (2001) from a

natural/positivist perspective scientists are based upon explaining, while from the humanistic perspective scientists are based upon understanding the human experience.

Furthermore, human sciences argue against the dominant positivist view of an objective, empirically-derived reality and instead depend upon phenomenological and post-modernist perspectives. From a humanistic view point, counselling psychology research is informed by phenomenological traditions and focuses upon a more collaborative attitude and co-operative inquiry (Strawbridge, 2006). From a human science position an interpretatively-focused investigative activity needs an empathetic understanding of the person's personal and social world. Research on psychotherapy from that vantage point can therefore highlight that psychotherapy inevitably involves interpretation of meaning.

The above stance is highlighted by Woolfe et al., (2003) who argue that the field of counselling psychology has its roots in the humanistic/existential tradition. It is therefore concerned with subjective meaning and experience and with an emphasis on relational being rather than on objectivism. Given the above epistemological and philosophical positions it focuses upon *lived experience* that is studied through the application of the phenomenological method that is respectful of diversity and difference and encompasses the context within human beings are embedded (Spinelli, 2005). Counselling psychology is therefore closely related to phenomenological psychology as both fields attempt to understand the human condition as it manifests itself in lived, concrete experience (Spinelli, 2005).

Customarily, it is a project's topic of investigation and in particular the research question that indicates what method of analysis should be conducted. The aim of this study is to describe what the existential approach means to practitioners and then attempt to understand their lived experience, what it means to work as a practitioner with cancer clients. A qualitative research method and specifically the descriptive-interpretative branch of qualitative methods was perceived as the most appropriate for this study.

Descriptive-interpretative methods allow the researcher to mix and match using an approach that best fits his/her research needs as it will be presented below. An interpretative phenomenological analysis was conducted for this study. In addition, following Braun & Clarke's (2006) suggestion that thematic analysis could offer a nuanced account of the data, this method was complementary chosen for the analysis of the first research question which aimed at providing a rich description of what practitioners consider existential practice.

Existential – Phenomenological Psychology

The practice of counselling psychology focuses on the subjective experience of individuals, their feelings and meanings. Existential-Phenomenological Psychology was seen by Valle et al. (1989) as an alternative to traditional psychology that results from blending the two interrelating perspectives (Valle et al., 1989) following the views of Søren Kierkegaard the founder of existential philosophy and Edmund Husserl the father of phenomenology. In Kierkegaard's view philosophy aims at highlighting fundamental issues that human beings struggle with. For Husserl, phenomenology is the study of things '*as they appear*' in order to get an understanding of human experience and consciousness. Husserl (1970) was concerned with '*direct and immediate experience*' as lived by the human being; its '*lifeworld*'. The '*lifeworld*' is co-constructed in the dialogue between the person and the world and expresses the total interrelatedness of beings and the world (Valle et al., 1989). Since phenomenology allows for an in-depth exploration of how phenomena appear to us and how we can create meaning of such phenomena; it provides a valuable contribution to methods of studying human experience.

For Valle et al. (1989) *Existential phenomenology* is seen as a discipline '*which seeks to understand the events of human existence in a way that is free of presuppositions*' (Valle et al., 1989, p.6). It is therefore in contrast to the attempt of producing an objective statement about an object or event in itself and also examining this event in terms of pre-existing conceptual or scientific criteria. When applied to human psychological phenomena, existential-phenomenological psychology has become a '*discipline that*

seeks to explicate the essence, structure, or form of both human experience and human behaviour as revealed through essentially descriptive techniques including disciplined reflection' (Valle et al. 1989, p. 6).

Interpretative Phenomenological Analysis

There are numerous methodologies used by researchers for the detailed analysis of qualitative data. In this study, an Interpretative Phenomenological Analysis (IPA) and Thematic Analysis have been conducted.

Interviews are one of the major approaches in collecting data in qualitative research (Kvale, 2007). A qualitative research interview aims at understanding the world from the subject's point of view, unfolding the meaning of participants' experiences and uncovering their lived world prior to scientific explanations (Kvale, 2007). Semi-structured interviews were conducted as a method of data collection for this study. Transcription of those and a systematic qualitative analysis followed.

The intersection of phenomenological philosophy and psychology forms the proposed research project which will focus on describing in detail the experience of offering existential therapy to clients suffering from cancer. Additionally, this study aims at identifying the practitioners' understanding of the existential approach to therapy. Consequently, the first question of this study was exploring the participants' conceptualisation. As this was thought to be a descriptive question a thematic analysis was chosen as a method of analysis of participants' accounts of this question. For the remaining questions of the study IPA was used.

Theoretical underpinnings of IPA and Thematic analysis

IPA was developed by Jonathan Smith in the 1990's initially designed to bridge the gap between cognitive and discursive psychologies. It is informed by phenomenological psychology and focuses on how people perceive an experience; a focus on the *lifeworld* which is the core of phenomenological inquiry as mentioned above. This method was considered to be the most appropriate for the second part of this project as it places less emphasis on description than the descriptive phenomenology but also engages with mainstream psychological literature (Langdrige, 2007).

In addition to IPA, thematic analysis was used for the analysis of the first question of the research exploring the practitioners' stance in relation to the existential approach to therapy. A description of the two methodologies employed will follow.

Thematic analysis is a method used for identifying, analysing and reporting themes within data. It is considered a foundational method of qualitative analysis as it provides core skills that are useful for other methods of analysis. For this reason, Boyatzis (1998) characterises it not as a specific method but as a tool to be used across different methods.

Thematic analysis differs from other analytic methods such as discourse analysis, IPA and grounded theory. In contrast to IPA and grounded theory that are theoretically grounded, thematic analysis does not lie to a pre-existing theoretical framework. This allows for flexibility to be '*an essentialist or realist method, which reports experiences,*

meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society' Braun & Clarke (2006, p. 9).

In practice, thematic analysis involves distilling from the texts the common themes in an attempt to identify commonalities across participants. An inductive, '*bottom-up*' way of thematic analysis has been adopted, meaning that the themes identified were strongly linked to the data. Following Howitt (2010), an attempt was made to name themes using the participants' actual words. In addition, following Braun and Clarke (2006) in this approach data was not driven by the researcher's theoretical interest, rather it was attempted to code the data without '*a pre-existing coding frame or the researcher's analytic preconceptions*' (Braun & Clarke, 2006, p. 12).

Interpretative Phenomenological Analysis on the other hand, emphasises engagement and involvement with participants' accounts and attempts to adopt an '*insider*' perspective (Smith, 2003) and tries to stand on the participant's shoes. This method does not account for an '*objective truth*' rather emphasises interpretation and attempts to capture the experiential quality of participants' accounts. Its aim is achieved through interpretative activity on the part of the researcher. It involves a dynamic process where the researcher has an active role. The researcher attempts to get close to the participants' personal world, acknowledging an interaction between the participants' accounts and his/hers own interpretative stance. This stance is in line with Heidegger's views on hermeneutic interpretation and notions of understanding meaning (Langdrige, 2007).

A phenomenological methodology involves accounts of lived experiences recognising

the need to account for the influence of the researcher in the data-collection and analytical process. IPA emphasizes that such an understanding involves a process of interpretation by the researcher (Langdridge, 2007).

IPA is concerned with understanding individuals' lived experiences and how they make sense of them. It therefore regards people as interpreting and meaning-making individuals. There is consequently a dual interpretation process going on or a '*double hermeneutic*'. '*The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world.*' (Smith & Osborn, 2008, p.51). Understanding the participants' experiences is becoming complicated by the researcher's conceptions. Smith and Osborn (2008, p.54) state that the term '*understanding*' is a useful one for IPA because it encompasses two aspects of interpretation, one of '*understanding in the sense of identifying or empathizing with and understanding as trying to make sense of*'.

As such, IPA is an inductive and idiographic approach concerned with understanding an individual's personal account of a particular experience without making generalisations or hypotheses and rather than trying to find causal explanations for events or produce objective '*facts*' (Smith & Osborn, 2008). IPA assumes that the researcher is interested in learning something about the participants' psychological world. This includes beliefs or constructs that arise from the participants' responses. In addition, IPA allows for ideas and themes to emerge from the personal accounts of participants rather than imposing a predetermined theory. Therefore, it brings to life possibilities that had not been initially considered by the researcher.

IPA is explicitly involved within an interpretative framework, which recognises the researcher's personal influence in the analysis of the data. In terms of '*reliability*' Giorgi (1985) argued that '*bracketing*', the attempt to suspend any preconceived assumptions and attributions, is to be found in most forms of IPA. However, this idea, also known as '*epoché*', (Husserl, 1970) is used in order to facilitate a reflective awareness during the process of interpretation of participants' accounts. In other words, '*bracketing*' in this context does not imply a disengaged, objectivist stance towards analysis, but retains an affiliation with the Heideggerian epistemological stance.

Lastly, as IPA is involved within an interpretative framework, reliability within this methodological framework is bound to lose its importance and is instead replaced by the notion of reflexivity, meaning, the researcher's awareness and critical reflections upon his/her own standpoint in relation to the analytic process and findings.

It is believed that there is a relational dimension to phenomenological research. Much of the information provided is hidden in the intersubjective interaction between the researcher and the interviewer. Finlay and Evans, (2009) developed a specific relational approach to phenomenological research drawing from concepts of the existential phenomenological philosophy relational psychoanalysis and intersubjectivity theory.

As the topic of investigation required reflection upon personal and sensitive experiences a relational approach was followed during the interview process. Finlay and Evans (2009) suggest an active interaction, a co-constructed research relationship similar to the therapeutic one that leads to emergence of data *between* participant and researcher.

Potential limitations of IPA

IPA is a relatively new approach that it is still being developed and reviewed. Consequently, there are variations on the way in which it has been applied by various researchers. In addition, it is a method mainly used within the field of health psychology and is still very new to other disciplines. One of the issues often highlighted regarding the IPA is the fact that it is a lengthy and detailed process. A lot of time is required to analyse the data in depth and also a significant amount of time and commitment is required from the researcher (Larkin et al., 2006). Another criticism that IPA often receives is that it relies on language and text. Consequently, this means that it greatly depends upon the interviewees' ability to express themselves.

Validity and quality of IPA

Smith et al. (2007) proposes Yardley's (2000) criteria for evaluating validity and quality of an IPA study. Her criteria will be presented below and have been followed in the process of conducting this study.

Yardley (2000) presents four principles for assessing the quality of a qualitative project: *sensitivity of context, commitment and rigour, transparency and coherence and impact and importance*. Firstly, a good qualitative study should demonstrate sensitivity to context. The socio-cultural setting in which the study takes place, the existing literature on the topic being investigated and the material obtained from participants are areas

requiring the researcher's sensitivity. In addition, sensitivity is also demonstrated through an appreciation of the interactional nature of the interview process. Smith suggests that a good IPA analysis is as good as the data it has derived from and obtaining good data requires awareness of the interview process. Sensitivity to context is not only relevant in the interview process but continues in the analysis of the data too. Specifically, *'Making sense of how the participant is making sense of their experience requires immersive and disciplined attention to the unfolding account of the participant and what can be gleaned from it'* (Smith et al., 2007, p. 180).

A good IPA study should be sensitive particularly to its data. In order to do so a considerable amount of quotations from participants' accounts will be provided to support each argument and check the interpretations that have been made by the researcher. Sensitivity to context can also be shown through an awareness of the existing literature. Relevant existing literature was reviewed in order to learn more about the experience under study as it has been previously presented and in the following chapters the findings will be presented and then discussed in relation to relevant literature.

Commitment and rigour is the second criterion to a good IPA study. One of the many ways that commitment can be demonstrated is through attention being paid to the participant during the interview process i.e. attending to what the participant is saying and ensuring they feel safe and comfortable, and the care with which each interview was analysed. Rigour refers to the appropriateness of the sample to the questions of the study (in this case a homogenous group) the quality of the interview (in-depth

interviews, picking from important cues from participants and exploring them further) and the completeness of the analysis conducted (analysis conducted thoroughly and systematically). In addition, a rigorous analysis should have sufficient ideographic engagement, move further from simple description to sufficient interpretations of what it means, for example, to work with clients diagnosed with cancer. Finally, the good IPA study aims at telling the reader something about the particular individual participant as well as the common themes between them. In order to demonstrate rigorous results extracts from each participant will be presented to illustrate each theme.

The third principle Yardley (2000) suggests is *transparency and coherence*. The stages and processes of the research will be clearly provided below including the selection criteria for participants, the process of interviews and the steps followed in the analysis of the data obtained. Another very important element in a coherent study is the degree of which the research has been conducted and its theoretical assumptions of the methodology being implemented. This research should therefore be consistent to the underlying principles of IPA, demonstrating the phenomenological and hermeneutic sensibility.

The fourth and final principle is the *impact and importance* of the study. As Yardley (2000) suggests the real validity of a study lies within whether it has something to say to the reader, something new, interesting and useful. In this particular study this was the very first thing that was considered when choosing the topic of research. Finally, Smith

et al. (2007) was read repeatedly and has been used as a guideline throughout this study in order to conduct a high quality IPA study as possible.

The role of the researcher

In qualitative studies the researchers themselves are an important part of the process in terms of their own personal presence as researchers but also in terms of their own experiences in the field (Kvale, 2007). Although IPA is clearly influenced by Husserlian phenomenology in its aim of understanding the individual's experience, there is a significant difference between the two. IPA does not seek to bracket the researcher's values and beliefs. Instead, it views these as necessary in understanding and making sense of the person's experience (Shaw, 2001). In addition to the phenomenological focus, the influence of Heidegger's hermeneutic phenomenology upon the development of IPA is therefore seen through the emphasis placed upon interpretation and the role of both participant and researcher in a dynamic process. For this reason, reflective sections have been included throughout this study.

Reflexivity

Finlay and Evans (2009) propose ten core values underpinning relational research; related to the researcher, to the co-researcher, to the research relationship and to the research outcomes. During the research procedure I attempted to keep those values in mind and to act in accordance to those as I believe them to be very valuable for every qualitative study.

Throughout the research process, I have attempted to bracket my biases through particular attention to reflexivity. Underwood et al (2010, p.1586) define reflexivity as *‘(a) the acknowledgment and identification of one’s place and presence in the research, and (b) the process of using these insights to critically examine the entire research process’*. Reflexivity was used in this study as a way of enabling me to reflect upon and analyse how my personal experiences and social processes have shaped the conclusions I have arrived at. In this chapter I will reflect upon my contribution to this study and in particular the beginning stages; designing the interview questions, conducting a pilot study and the process of conducting the interviews.

Up, close and personal

Throughout the process of conducting this study I had the opportunity to reflect upon myself, my issues and my personal and professional development. A presentation of those thoughts will be provided below followed by my reflections upon their presence in this study. As mentioned previously this study addresses important human issues such as

health and illness, death and dying. Consequently, it is important to provide my thoughts upon those issues in an attempt to understand how my views might have impacted upon this study.

Reflecting upon existential issues

On a personal level, I believe am aware of the temporal nature of my existence. However, what I fear the most is the physical deterioration that comes with illness, the slow and painful dying rather than vanishing from life. From a young age I have struggled to project myself in the future. I could never ‘*see*’ myself within a ten year prospect. My interpretation of this is my recognition and possible fear of the unknown and the end of life. There are two sides to this. On the one hand, I am ‘*forcing*’ myself to live in the present, plan only the near future saving myself from disappointment and feeling some sort of safety. After all, thinking about future always entails anxiety. On the other hand, this attitude can be disheartening and prevent me from making plans as ‘*you never know what happens*’ or ‘*I might not even be around by then*’ which often brings up feelings of futility. I find this irrational thinking also present in my relationships ordering not to get too close as you never know if it is going to be there tomorrow.

Another theme I believe is important to provide my thoughts upon is loss. I believe there is a double meaning to loss. Missing something or someone that existed but also missing something you never had. In both cases mourning takes place and the experiences can be equally painful. Loss, with both its meanings, has had a significant

part in my life as well as my personal therapy and development. My experiences involve all kinds of losses, losing people and pets to death or break ups in relationships, loss of context and identity when moving countries, loss of intimacy within my family and also being an only child which I consider a '*handicap*', a lost or never existing relationship that has definitely shaped my ways of relating described previously. I believe loss is a theme that I don't handle very well and still working on. It is one that causes a great fear and anxiety and is very present in my life.

Relating

My peer supervision group had offered significant input and support while I was exploring all those issues and their relevance to this particular research project. What has fascinated me the most during this reflection process was reviewing my relational patterns.

The polarities of *presence-absence* and *engagement-detachment* are core characteristics of the ways I tend to relate. I can trace this back to several relationships in my life whether those are intimate ones, friends and family, my pets and even the way I relate to my clients. There is no significant difference in the way I relate to projects in my life or even this particular project. I tend to want to get close to others and the world but at the same time I find myself needing a distance that to me provides safety.

As mentioned above I can track this pattern back to my early life as well as my family's dynamics. I strongly believe this is one of the reasons that prompted my decision, at a very young age, to become a counselling psychologist. The therapeutic relationship has

unique qualities that are very important to me. It is one that is very close, secure, intimate, and supportive and can be very emotional. Often, it is something most clients had never experienced before and the same applies to me. Nevertheless, I strongly believe the practitioner's style and ways of relating colour significantly the picture of the therapeutic relationship. What I find intriguing in my practice is the balance between *'engagement and detachment'* within the therapeutic relationship. The boundaries and the professionalism of its nature offer the distance I found myself comfortable in. However, ever since I recognised the above I have challenged myself out of my comfort zone, exposing and expressing my self and attempting to stay longer in the *'engaged'* part of the relating.

Reflecting upon the research journey

Having presented my thoughts and ideas in relation to the issues addressed in this study I will subsequently focus on the process of this research.

Asking the right questions

As this study arose from a personal interest and in an attempt to answer some of my trainee-therapist anxieties in relation to this particular client group, it was important to ensure that my questions were not biased and carefully formed. Forming the interview questions was not an easy process as there were several things I wanted to ask my participants. My limited research experience was obvious when I presented to my supervisor with a page filled with questions. With her guidance I realised my anxiety and need to cover as much as possible in an interview and prevent the hatred possibility of not getting adequate information from the participant. At that point I realised that the interview process can be similar to a therapeutic discussion and that the use of open questions and the often overlooked basic counselling skills could be invaluable. In terms of the content, questions were divided into two parts; one exploring the clinical approach used by the participant in his/her clinical practice followed by an open question regarding the experience of working with clients diagnosed with cancer. Prompt questions were also considered in regards to other issues relevant to this study such as the context of their clinical practice, length of therapy, their training et cetera.

The pilot study

Conducting a pilot study was very useful as it provided me with information on how to improve my questions and reflect upon issues that might arise during the interview process. Also, I had the opportunity to use this pilot in order to better prepare myself. Since this was my very first interview conducted from a researcher's point of view it was accompanied by significant anxiety. The most significant discovery during the pilot interview was confusion in the focus of the interview possibly caused by my inexperience. On a few occasions the client rather than the therapist became the focus of the discussion. I attempted, although not always with success, to encourage the participant to go back to her own feelings, experience and the meaning they have for her.

This pilot study gave me the opportunity to review the questions used in the subsequent interviews in order to make sure the focus remained on the therapist's. Reflecting upon the experience of conducting the first interview, the pilot study, I became aware of '*colluding*' with the participant and being drawn to the client's experience. This was something that I considered and carefully monitored during the subsequent interviews.

Upon reflection, further to my inexperience, talking about the client possibly made it easier for both of us as I felt I was colluding with the participant and avoided digging deeper into her experience and feelings. I found myself feeling I was '*walking on egg shells*' as I didn't know how deep and personal this interview should be. Consequently, this first experience provided useful information and food for thought. I reviewed the

research questions and in the following interviews I attempted to distil as much information as possible.

Lastly, analysis of the pilot interview using IPA provided a first experience of qualitative analysis. This analysis process was also informative in relation to the interview process as I then had a clearer picture of what I was looking for in the following interviews.

Reflections upon the interview process

Recruitment of participants was not an easy process. There is a small number of practitioners who have completed a training in the existential approach and even a smaller one of them working with clients diagnosed with cancer. Recruitment was therefore a stressful process and what added to it was me still feeling disappointed that I had to change my original research idea. My feelings changed dramatically as practitioners responded to my invitations to participate and interviews were being arranged. This was the point when I felt this journey into exploring personal experiences was beginning.

In the process of conducting the interviews I encountered several difficulties and feelings that I am going to explore further below. In the final chapters reflections will be further unfurled also in relation to their relevance to the outcomes of this study. An initial difficulty I encountered was an attempt to balance my two identities, the researcher and the therapist. At times, during the interviews I felt the process closely

resembling the therapeutic encounter. The participant was asked to reflect upon very personal experiences and feelings that I carefully and empathetically listen to. I occasionally found myself feeling unsure about how *'deep'* those conversations should be, how much personal information I should ask for and whether it was appropriate to go into deep personal feelings. This feeling was very intense with participants A, C and E who had powerful personal experiences related to cancer. Furthermore, their experiences were also bringing up my feelings around cancer and my personal experiences that were very raw at the time so I found myself attempting to bracket my thoughts and feelings and stay with the participant. Again this brought to mind a similarity with the therapeutic encounter and added to my choice of conducting this study. So thoughts like: *'if I am feeling that way here, now, how would a therapist with similar experiences feel like when being with a client?'* The answer was sitting in front of me but also I was *'offered'* by participants a first-hand experience of what it is like to sit with someone who has personal experiences related to cancer.

Analysis of the data collected from the interviews paid attention to the individual's being-in-the-world as well as interpersonal dynamics taking place during the research relationship. In particular, it is recognised that the participant's experience will impact upon the researcher consciously and unconsciously. Those conscious and unconscious relational dynamics take place during the interviews but also before and after are explored reflexively below (Finlay and Gough, 2003).

During the transcription process I became aware of the impact of my hesitation to deepen into the participants' experiences upon the data obtained. Even though the

experiences were captured, it was not to the extent I expected or wanted. A particular example illustrating this process is talking about death. As it will be presented in the results section of this paper, participants struggled to openly explore with their clients their possible death during the therapeutic process. I felt a parallel process was occurring as during the interviews there was also a tendency to talk around the issue of death but not discussing it openly. However, this is a learning curve for me that will prove to be useful in future research projects as the importance of paying close attention to designing the questions and prompts and carefully picking up and exploring further what the participant shares during the interview, was understood.

It is also important to refer to some significant moments in the process of conducting the interviews, moments that caused significant emotional reactions. Participant D was one that troubled me significantly but also provided rich material for me to reflect upon. It was unfortunate that the place where the interview was taking place became very noisy and busy and that affected significantly our communication. Similarly with the pilot interview, I struggled to keep the focus of our conversation to the participant's clinical practice in relation to cancer clients. She had extensive experience working with cancer clients but this was all in the past. I was aware of her tendency to talk more about the present and her clinical practice now, rather than of what the focus of this interview was supposed to be. At the time I felt frustrated and exhausted as I put great effort to distil any feelings and information relevant to what my study was about. I felt disappointed and even considered not to include this interview in my data. Upon reflection, this process provided considerable information not so much in terms of quantity but definitely in terms of quality. What was happening between us was important and her

struggle to talk about those experiences was also important. As it will be discussed later on, even though the quantity of what she disclosed related to working with cancer clients was not much, there was significant emotion attached to what she did disclose. Her difficulty possibly shows the greatness of emotions associated with this practice. For her too, as this most participants and myself, this work had personal meaning as she had lost a parent from this illness.

Participant C planted the seed of a very important issue during our interview that only much later on I realised was there. She had rich experiences in relation to cancer not only on a professional level but also on a personal one. Her talking more about her personal experiences instead of the professional ones brought again feelings of frustration during the interview however; I allowed that to happen as I felt it was important at the time. In retrospect, I realised that her personal experiences were closely linked with her choice of working with that particular client group.

Lastly, in retrospect and upon further reflection on Finlay's (2011) relational approach to phenomenological research I recognised a limitation on most of my interviews which was failing to focus more on the here and now experience of my participants. I assume this might have provided interesting and useful material for both of us to reflect upon.

Conducting the interviews and the consequent transcription of those was a great learning experience. Overall, I felt a sense of gratitude when participants got more personal, sharing some of their own life experiences either in relation to cancer or their path to becoming therapists. Lastly, in order to recruit participants I travelled around UK to places I never had the chance to visit before which I am also grateful for.

Method

The research process

Following approval of the research topic and ethical approval by Middlesex University and NSPC ethical boards, a pilot study was conducted. The pilot study gave me the opportunity to reflect upon the questions involved in the interview as well as practice the IPA as a method of analysing data. From the analysis of the pilot study the following themes emerged:

EXISTENTIAL THERAPIST'S EXPERIENCE OF WORKING WITH CLIENTS DIAGNOSED WITH CANCER

1. Therapist's conceptualisation of Existential therapy in Practice	2. Therapist's responses when Death enters the Counselling Room
1.1 Pluralistic attitude	2.1 Anxiety and Uncertainty
1.2 Working towards a deliberate way of being	2.2 Up, Close and Personal; blurring of boundaries
1.3 Existential therapy is the relationship	2.3 Departing from the existential attitude
	2.4 Could I have done a little more?

1. Themes and Subthemes emerging from the Pilot study

At this particular interview it was highlighted that working with clients diagnosed with cancer can be a challenging work on its own but even more when a client evokes personal experiences and unresolved issues for the therapist. In this particular case, the participant struggled with his unresolved guilt and loss of a relative who died of the same illness as his client. The participant seemed to be affected by both his personal issues as well as by his client's circumstances on several occasions. He was emotionally affected feeling anxious during the sessions because of the uncertainties involved in the client's illness and also fearing that the therapy could end up being about his own feelings. In terms of his practice he was much less phenomenological than usual, not exploring and noticing the obvious. Finally, from the researcher's point of view, in terms of working existentially several issues that an existential therapist would probably attend to were omitted or could have been explored further such as the client's physical world, her anxieties and possible death.

'But we never really explored the cancer itself or the possibility of dying or the fact that she was feeling ill frequently you know all the physical aspects of it never really came into it'

'I think she should have been either given the opportunity to be seen long term'

Pilot

Formulation of the research questions

An in –depth literature review was conducted in order to get a greater understanding of the topic investigated. Research papers, case studies and books in relation to in-hospital practice, death of a client, existential-phenomenological practice and practitioners' experiences were reviewed as provided above.

Having chosen IPA as a methodology, the interview questions were seeking to capture how the participants made sense of their experience of offering therapy to clients diagnosed with cancer. Initially, a list was made with all possible questions. While designing the questions I became aware that my lack of experience in this particular topic was an advantage as there was a genuine interest and no personal experience to compare to but also I was careful and aware of my assumptions and what I imagined such an experience would be like. An attempt was made to bracket those assumptions and be open to understand and capture the meaning of this experience for each participant. Those questions were then summarized, rephrased into open questions and the number was reduced. It was noted that there were two areas to be explored: the participant's way of working in relation to the existential approach and how it was for them to work with clients diagnosed with cancer. It was later on observed that the first question was a descriptive one that did not require any level of interpretation from the researcher. Rather it should summarise and present the common themes among participants. Consequently, thematic analysis was used to analyse their responses.

Within those areas there were prompts looking at how the existential approach and philosophy came into participants' clinical. Following the first interview, the research questions were again slightly reviewed and further reading took place on qualitative analysis, thematic and IPA in particular. Please look at appendix 6 for the final questions and prompts that have been used as well as the interview process.

Participants – Inclusion criteria

IPA holds an idiographic emphasis therefore the aim of the study was not to generate large quantities of data but instead to gather quality information that would enable a deeper understanding of the participants' experience. For that reason, six people participated in the study.

Since IPA is not concerned with making generalisations, the group of participants was as homogeneous as possible. Therefore, participants were qualified therapists, in practice, adopting an existential attitude to therapy. In addition, participants were either working within a palliative care hospital setting or had worked with clients diagnosed with cancer in their private practice. When the study was initially designed it was intended to recruit participants who had completed training in the existential/phenomenological approach and were working from that vantage point. However, it was not possible to recruit six participants fulfilling those criteria. Therefore, two people were recruited that had not completed an existential training in particular. However, they claimed to have working knowledge of the approach as this was an essential requirement for their participation.

Participants that worked in a variety of settings were selected in order to provide a wide range of settings and experiences. Potential participants who did not have working knowledge of the existential-phenomenological approach were excluded. It is important to note that recruitment criteria did not look at the number of clients therapists have seen as this study's focus was not a matter of quantity of experience.

Recruitment process involved leaflets being displayed at the New School of Psychotherapy and Counselling (NSPC), Regent's College and services offering therapy to clients with cancer. In addition an email was circulated using the NSPC and the Society of Existential Analysis (SEA) database.

A table summarizing the participants' characteristics such as: level of training, theoretical orientation, years in practice post accreditation, primary area of employment at present and the frequency of work with clients at present diagnosed with cancer is presented below. Any identifiable information has been removed in order to protect anonymity and confidentiality.

Participant	Highest level of psychotherapy training	Theoretical Orientation	Years of practice post accreditation	Primary area of employment	Frequency of work with cancer clients
A	Master's	Existential/ Phenomenological	1-5 years	Private Practice	Occasionally
B	Master's	Existential/Phenomenological	11-20 years	NHS/Cancer counselling service/ Private Practice	Regularly, primary area of work
C	Master's	Integrative	6-10 years	NHS Services	Occasionally now/ Primary area of work in the past
D	Diploma	Integrative	1-5 years	Private Practice	Rarely now/ Regularly in the past
E	Doctorate	Integrative	6-10 years	NHS Service (Cancer Service)	Regularly, primary area of work
F	Doctorate	Existential/ Phenomenological	11-20 years	Private Practice	Occasionally now/ Regularly in the past

2. Summary of Participants' details

There was a variance of experience among participants. In terms of the context of their clinical practice with cancer clients, some participants worked or are still working exclusively in hospital settings, palliative care or psycho oncology units or organisations providing support to cancer patients and their relatives. Participants D and F had extensive clinical experience with cancer clients and were regularly working in that context in the past; however at the time of their participation in this study they were only working privately consequently the number of cancer clients they work with now is significantly lower.

Data Collection

When potential participants responded via email on the call for participants, they were once more asked whether they had working knowledge of the existential-phenomenological approach and experience of working with at least one client with cancer and whether they felt confident to reflect upon their experience. Subsequently, the participant information sheet was sent to them. If participants fulfilled recruitment criteria an appointment was made at a place and time of their convenience in order to conduct the interview. At the beginning of the interview participants were once more explained the nature and purpose of the study, confidentiality and data protection were explained and were then asked to give informed consent. Typical of phenomenological investigation the interviews lasted between 60-70 minutes. In order to achieve consistency of the interview a schedule with a series of questions and topics of discussion was used. For questions see appendix 6.

Semi-structured interviews were considered to be the most appropriate method of data collection since it was believed to give the participant the opportunity to articulate in as much detail as possible. Research questions according to Smith (2003) should be directed towards a phenomenological understanding and should be exploratory therefore; a number of open-ended questions were used to cover the topic investigated. Since an existential stance to therapy was a prerequisite in order to participate in the study, the first question, a descriptive one, was looking at the therapists' understanding of the existential approach and how it comes into their practice.

Ethical Awareness

Participants were provided with information regarding the research and its purpose prior to their participation in order to enhance their informed consent. They were informed about their right to withdraw from the study at any point; they were assured that all information will remain confidential and in case of publication altered so that their anonymity will be preserved. In addition, recordings and transcripts were kept safe and in accordance with the Data Protection Act 1998. Participants were assured that all data was only accessible by the researcher (and participants should they wished to) and will be destroyed upon completion of the study. It is understood that the well-being of the participant is the primary concern and everything should be done in order to avoid any kind of distress. Due to the nature of this research topic, participants were asked to elaborate on sensitive issues and experiences. In order to ensure their well-being and informed consent participants were provided with information about the study and were offered the opportunity to discuss any concerns with the researcher beforehand in order to be fully informed and judge whether they felt confident to participate. Please see Appendices 4 and 5 for the *Participant Information Sheet* and *Consent Form*.

In the event that participants experienced any kind of distress the researcher was able to use her clinical training skills so that she could attend to their issue, without providing therapy, but ensuring their well-being and providing the opportunity to end the interview.

A debriefing session followed each interview which provided the opportunity to all participants to ask any questions or clarify any issues that have arose during the

interview process. During the briefing session participants were able to express their feelings and reflect upon the experience of the interview as well as offer their feedback to the researcher.

This study has received a favourable Ethical approval by the Middlesex University and the NSPC. For all relevant documents please see appendices 1-3.

Data analysis

Procedure

The research interviews were audio taped, transcribed and then analysed. The analysis procedure will be presented below showing how the themes presented in the results section have emerged.

The analysis of the first question took place first. A Thematic analysis requires identification of a small number of themes that adequately describe what takes place in the text (Howitt, 2010). The procedure proposed by Braun and Clarke (2006) to thematic analysis was followed. Braun and Clarke (2006) provide a six stage approach to conducting thematic analysis recognising the inevitability of going backwards and forwards between the different stages of the analysis. This flexibility gives the researcher the opportunity to review and improve the analysis. The proposed stages that were followed are:

1. Familiarization with the data.
2. Initial coding generation.
3. Searching for themes based on generation.
4. Reviewing themes.
5. Defining and labelling themes.
6. Producing the report.

Initially, data was read numerous times. Following familiarization the researcher began coding the data. Brief verbal descriptors were applied to small amounts of data (few lines at a time). A coding is a label that describes the content of each line of the transcript (Howitt, 2010). At this stage the codings can be simple summaries of the text highlighting its essence. According to Braun and Clarke (2006) coding does not emerge from the data. *‘An account of themes ‘emerging’ or being ‘discovered’ is a passive account of the process of analysis, and it denies the active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them to the readers’* Braun and Clarke (2006, p.7).

The codings were then reviewed several times as new ideas kept developing. Based on the codings the researcher tried to identify themes that integrated sets of codings. *‘A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set’* (Braun & Clarke, 2006, p.82). The importance of a theme did not necessarily depend on its frequency but on whether it captured something important in relation to the research. During the process of analysis themes were reviewed several times in order to achieve consistency between data, coding and themes (Howitt, 2010). Attention was paid so that themes remained coherent, consistent and distinctive.

Thematic analysis has been criticised in terms of lacking consistent and transparent formulation (Howitt, 2010). This leads to numerous studies using it poorly and superficially. Even though initially as a method seems to be a simplistic one, the opposite becomes apparent once one gets involved in the process.

Upon completion of the analysis of the data obtained from the first question using thematic analysis, the rest of the data was analysed using IPA.

IPA involves a close contact with participant's accounts, as it is an idiographic approach each interview was analysed individually. As Smith suggests IPA gives the researcher flexibility in terms of the analysis (Smith, 2004, p.40). Smith's guidelines were followed during the analytic process as it will be described below.

The process of analysis included the following steps:

1. Each transcript was read repeatedly and audio was listened to in order to familiarize myself with the data.

2. Once this was achieved, notes were kept and key phrases and processes were identified. In addition, particular emphasis was given to the audio material, which was listened to repeatedly, in order to ensure that changes in the voice, pauses and hesitation of speech were not omitted. On the first stage of the analysis, following the repeated hearings and reading of the data, notes and comments were made on the transcript. In particular, anything that was considered interesting or significant was highlighted; descriptive, conceptual as well as linguistic comments and use of language were identified. In addition, some of the comments made were attempts to summarize or paraphrase. It was noted that every additional reading or hearing produced new insights. I was careful in bracketing my assumptions and preconceptions as much as possible. In addition, notes have been kept at the end of the interview regarding the non-verbal

communication and general comments were reviewed as it was believed they could be useful in the analysis.

3. Following this process the interpretative stage took place, through bracketing and invoking my theoretical and psychological knowledge. IPA aims at '*moving from the particular to the shared and from the descriptive to the interpretative*' commits at understanding the participants' point of view and focuses on the meanings they construct (Smith, et. al., 2009, p. 79).

The notes that were made on the text were reviewed and a description of the interview was written down focusing on what I learned from each participant, what stayed with me during the interview process and analysis. This also helped me in identifying any possible personal assumptions that I should attempt to bracket.

4. Next, themes emerging were identified. Themes were noted, defined, named and listed in chronological order then reviewed and transformed into more meaningful statements trying to reflect the broader meaning of a particular section. Emergent themes served as umbrella themes and subthemes were also identified.

5. The original transcript was revisited in order to stay close to the participants' original words and illustrative quotes that highlighted the emerging themes were identified. This process was followed for each interview individually.

6. The meaning of the participants' experiences was extracted by engaging with the data in an interpretative style which led to the identification of themes (Smith, 2008) presented in appendix 7.

7. When themes and subthemes were identified for all interviews, in the final step of the analysis, cross themes were clustered between the six interviews. As it was not possible to incorporate all themes, their importance was re-evaluated and some were discarded. An effort was made to put together the emergent themes and produce a structure that allows for the interesting and important themes to emerge. Smith's (2008) suggestion was followed at this stage. A list of all themes was made and then themes were clustered together forming the super-ordinate themes.

8. A table was created with all themes, subthemes and illustrative quotes in order to review them and look for connections between themes. A more analytical ordering took place as it was attempted to make sense of the connections between the themes. An attempt was made to identify the meaning of the participants' experience through understanding the '*content and complexity of those meanings rather than measure their frequency*' (Smith & Osborn, 2008, p.66). Up to this stage of the analysis there was a tendency to move from the part to the whole whereas now there is a deeper, more detailed analysis of the part. Again going back to the original text was necessary in order to ensure that the themes reflected the participants' experience. Those super-ordinate themes will be presented below in more detail.

Analysis

Overview

The analysis of the interviews revealed rich material and an attempt was made to capture participants' experiences. Unavoidably, there will be overlaps and lapses across the themes. An insight of the complexity of each participant's lived experience and their meaning-making of it will be offered below. Verbatim extracts are provided throughout the chapter in order to better illustrate the experience and facilitate contextual meaning. A table of the super-ordinate themes and illustrative verbatim quotes can be found in Appendix 8.¹

A summary of the Super-ordinate themes and Sub-themes is presented in the table below.

?

¹ _____

Verbatim extracts: The extracts included have been amended to facilitate readability and preserve anonymity. All identifying information has been deleted or altered. Bold words have been used to indicate participants' emphasis.

Transcript notation:

I Interviewer
R Responder.
... Long pause
(...) Text omitted
[] Authors comments

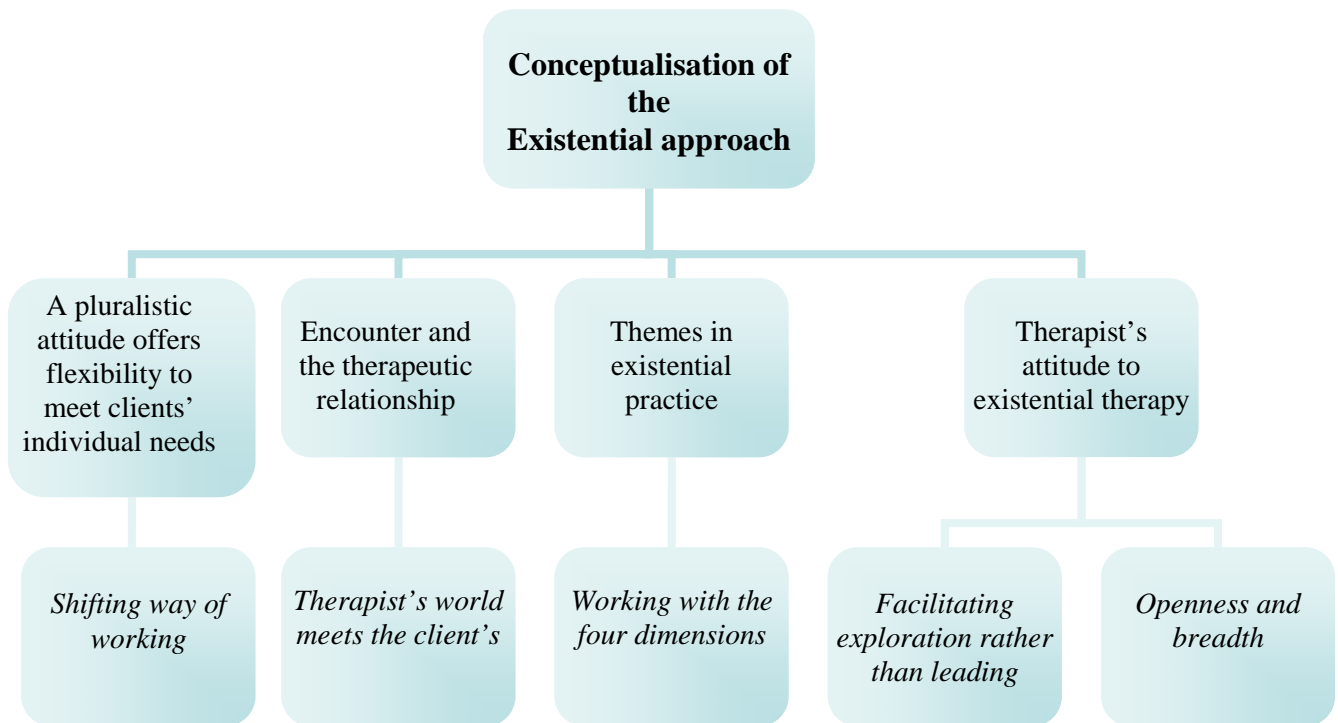
**THE EXPERIENCES OF EXISTENTIAL THERAPISTS WHO HAVE WORKED WITH
CLIENTS DIAGNOSED WITH CANCER**

1. Therapists' conceptualisations of the Existential therapy	2. Emotional impact of the work on the therapist	3. Implications in clinical practice with clients diagnosed with cancer
1.1 A pluralistic attitude offers flexibility to meet clients' individual needs	2.1 Dealing with anxiety, uncertainty and unexpected endings	3.1 Additional dimensions to be considered regarding this kind of practice
1.2 Encounter and the therapeutic relationship	2.2 Awakening of personal experiences	3.2 Working with existential issues and death being present in the counselling room
1.3 Themes in existential practice	2.3 A very close relationship	3.3 Working with the physical dimension
1.4 Therapist's attitude to existential therapy	2.4 Finding meaning in the work	3.4 Therapist's preparedness and vigilance

3. Table of Super-ordinate themes and Sub-themes

Emergent themes

1. Therapists' conceptualization of the existential-phenomenological approach to therapy



Overview

The existential-phenomenological approach to therapy is not easily defined. As participant B states *'it means many things to many different people, many different people will give you many different answers'*. For that reason participants were asked to

elaborate upon their understanding and way of practicing existential therapy. A thematic analysis was conducted for this question leading to the themes presented below.

Most participants referred to the influences of their existential thinking and practice. It was interesting to notice the variety of existential thinkers and practitioners that participants have been inspired by.

'I come from a more Heideggerian sort of perspective. So – and it's the later work of Heidegger in recent years that I've found particularly influential for me and also working within this context (Palliative care)'
B.

'French philosophers and French thinking and it was really the French writers that most appealed to me and in particular Merleau-Ponty. So I suppose my orientation would be one that's full of post-modern ideas from relational therapy, even relational psychoanalysis, but it's mainly based upon the strand of thought that runs through Merleau-Ponty and Pierre Bourdieu. Having said that, I'm also quite influenced by people like Lang, R D Lang and also a lot of feminist writers.'
F.

'I've learnt lots of literature, not necessarily professional literature but world literature, French literature around the end of the century which is very much in character with - from that approach really and within that philosophy. (...) I'm familiar with Nietzsche's ideas and Heidegger's'
E.

Contemporary existential practitioners such as Irvin Yalom, Emmy van Deurzen and Ernesto Spinelli seem to have also influenced participants in terms of their way of practicing.

Research by Wiles & Milton (2006) identified that practicing existential therapy was for some therapists associated with practicing phenomenology and for others the focus of their work was on the therapeutic relationship. As it will be presented below, this study produced a similar finding.

1.1 A pluralistic attitude offers flexibility to meet clients' individual needs

From participants' responses a tendency towards a pluralistic attitude to therapy was evident. Participants claimed that adopting additional techniques, borrowing from other approaches whilst feeling grounded within the existential approach allows them to feel more equipped in order to meet each client's needs.

The existential-phenomenological approach is one that recognises and values individuality. Clients have different needs and respond differently to the various therapeutic approaches and techniques. Consequently, therapists need to be flexible in adapting their way of working and meeting their clients' individual needs.

Wilkes & Milton (2006) identified examples where existential therapy is combined with other psychotherapeutic theories and techniques, such as use of body language, open-ended questions, dream work and reflection on clients' world-views. This highlights '*a tension between the conceptualisation of existential-phenomenological therapy as unique/individualised practice or as an approach with accepted procedures and protocols*' (Wilkes & Milton, 2006, p3).

Focusing on the participants' responses, participant A identified himself as an existential-phenomenological practitioner but also as pluralistic one as he claims to often shift his approach in order to meet the client's needs. The participant claims to adopt an existential/phenomenological stance in therapy that provides him with a theoretical background to work from. Furthermore, he feels able to be flexible and creative as the existential approach allows him to shift his way of working and draw from other approaches in order to meet the client's needs. He therefore considers himself a pluralistic therapist who holds the existential/phenomenological approach at the background but enriches it with for instance, cognitive behavioural techniques.

'I would say I would call myself an existential practitioner, an existential-phenomenological practitioner I allow myself to be informed by various different approaches. And I find it very valuable to sort of get input into my client work from different modalities (...) I consider myself as pluralistic i.e. that you know I see myself as grounded within the existential approach but if it is appropriate in the client setting for example to use CBT methods because that is what the client responds to best then I am not adverse to that really I can do it up to a point'.

A.

This stance highlights the importance of respecting client individuality and uniqueness. Each client has different needs and the participant seems willing to meet them. The existential approach offers an excellent theoretical background for therapists and at the same time as the participant claims, allows him the space to be flexible in terms of practicing.

'I felt it was important to do other things like relaxation which is Gestalt and working systematically. One client might work well with existential, one might work person centred but others, some will find it easier working systematically in CBT'

D.

'my heart is humanistic but I'm trying to really use things as appropriate to the patients' needs'

E.

Participant E also claimed to use other approaches in addition to the humanistic attitude she holds close at heart in order to meet her client's needs.

'part of my integrative philosophy is trying to match whatever the client needs and my way of working will vary to an extent according to the person and the way of working they want'

C.

Summing up, responding to clients' needs motivated participants to shift their therapeutic approach or enrich it by borrowing techniques and skills from other therapeutic approaches. Working knowledge of more than two theoretical orientations is therefore paramount for effective therapeutic work. The existential-phenomenological approach therefore provides practitioners with freedom and creativity in practice and at the same time offers a useful theoretical background. Most participants claimed that the existential-phenomenological approach gave them freedom and flexibility in their work, something they seem to value the existential approach for.

1.2 Encounter and the therapeutic relationship

It was anticipated that the therapeutic relationship would have a significant role in the participants' description of their way of practicing. It is considered to be the ground on which therapy is built on. Without a secure trusting relationship no therapeutic work can be done. From an existential-phenomenological vantage point human beings are always in relation; with themselves, the world and other people. This relatedness is present in the participants' way of approaching and working with their clients as it will be presented below.

'I think, you know I think the majority of my being with the client obviously I see the relationship as the most important aspect of the therapeutic... process in my therapeutic work and for me the existential approach lends itself best to form this therapeutic relationship because I do believe it allows me some freedom to sort of... be creative and not stick to certain rules or beliefs that other modalities ...in terms of applying to building the therapeutic relationship. I think I am quite free on that and I can be quite free on that because of my existential background and I like it and that's how I use it most'

A.

*'I've been working existentially and phenomenologically especially phenomenologically... I mean so the relationship is the main thing that you work with, so I think that it's very important it is you know oh gosh it's difficult to put in words... it's **the** sort of...it's what therapy is all about this is what you work with that's there, that's what you built'*

A.

For participant A the relationship is the most important aspect of therapy and in addition she emphasises the freedom the existential approach entails in the establishment of the therapeutic relationship.

'So yes I think the relationship is absolutely necessary to sort of go into deep areas I mean if the relationship isn't there you will be asking your clients to disclose and talk about thoughts and feelings that have never been talked about before and they may even don't dare thinking or feeling so... if the relationship is a secure base to do that to explore from you know the foundation for exploration... without that you can't really, there is nowhere to go. It's it... provides safety to sort of go places together so yeah I consider it very very important'

A.

'I've always sort of stayed quite close to the humanistic roots and treating the relationship as a core'

E.

Furthermore, the participant stresses that the establishment of a therapeutic alliance constitutes a prerequisite for entering deeper areas of a client's life. Recognising the difficulty assigned to such disclosure, the therapist views the establishment of the relationship as the *'foundation for exploration'*.

The therapeutic encounter was also described by participants as a space where the client's and therapist's worlds meet.

'... opening up their world and how they see the world. But also coming in I'm a person too in a relationship with them in the encounter so I will be bringing from my world and all that I carry with me, interaction that may be will then reflect on their world and may be challenge where I see that perhaps they could open up a bit'

B.

Relatedness is at the core of existential-phenomenological therapy and as Spinelli (2007, p. 20) claims it *'defines and identifies existential-phenomenology'*.

Participant B while trying to define existential therapy, emphasised that it is the way human beings perceive themselves and their clients as beings always in relation.

'(...) about being in the world and seeing people not as discrete individuals but always in relationship to the world and the people in it'
B.

'that's how you sort of reflect on each other's' being and the relationship and of course you translate it into a wider spectrum and that's hopefully encounter counter-dynamics that become patterns of relating to others that through the process of phenomenology you point out to the clients and hopefully they learn from it'
A.

In therapy, the client's world meets the therapist's. Each encounter is an original meeting in which new dimensions of experience are opened up for the client.

'I think that's the beauty of the work where we're an enabler, trying to enable them [the clients] to understand but of course we understand through our clients as well'
B.

Participant F emphasises the difference between the relationship and the encounter. The relationship is formed from a series of encounters occurring over a period of time whilst each encounter is a unique experience for both the client and the therapist.

'And so it's very much based upon an awareness of the distinction between the encounter, present encounter and the relationship which is something that is an abstract thing that's built up over a period of time based upon a series of encounters'

'I'm never the same therapist and my client is never the same client and we have to re-establish what this encounter is each time we meet'

'the danger for me is that the protection of the relationship would be counterproductive to the therapy because it would make us too frightened to really enter into an encounter which is difficult and challenging. And so I'm constantly at that sort of interface between encounter and relationship and trying to be as aware of that as I can'
F.

As mentioned previously existential therapists regard their clients as embedded within the world *'we are the world and in the world and the world is in us'* as participant F claims.

'I think the whole image of people within systems, for me there's no such thing as an individual, there is a person who has lots of connections in the world with other people and these connections build up who that person's identity...what that person's identity is'
F.

Furthermore, existential therapy, being a relational approach, is embedded within the humanistic values, the values of the therapeutic relationship as presented by Carl Rogers (1961) and the core conditions necessary for a successful therapeutic alliance.

'Rogers on Becoming a Person, there's a piece in there where he talks about being a trusted companion to his client in the terrifying search towards himself. And I would say that actually the purpose of therapy is to create a space where the client can meet themselves in ways that they've never themselves before, or in ways that they'd forgotten about. So the corollary to that is that I also meet myself in the therapy with the client in ways I wasn't expecting'
F.

The following quote from participant F summarises the purpose and emphasises the importance of the therapeutic relationship. The meaning of the therapeutic relationship

for him is to *‘try to create an atmosphere or a space where the unspoken can allow itself to be revealed and spoken about if the person feels able’*.

In the case of cancer clients, the *‘unspoken’* is referring to death. To conclude, participants’ responses seem to emphasise the openness of the existential approach in the establishment of the therapeutic relationship as it allows freedom to be creative and not to be guided by certain rules and beliefs. Establishment of the relationship is therefore a joint responsibility shared between the client and the therapist.

1.3 Themes in existential practice

While describing their way of practicing, participants referred to existential issues that they often work with. Those issues formed the third subtheme that provides an excellent illustration of the speciality and distinctive characteristics of the existential approach to clinical practice.

Existential therapy aims at addressing the existential issues in life. Exploration of the givens of existence is at the core of the existential way of practicing. Therapeutic work with clients diagnosed with cancer forces therapists to address those existential issues. For instance, participant A claimed that paying attention to the existential givens and limitations of existence is at the core of his practice as an existential practitioner.

I: (...) what else is existential in you practice? How does the theory come into your practice?

P: I pay attention to... existential givens I suppose of course in...you know how the client is presenting, what the client is presenting'

A.

Reflecting on a more personal level, participant A recognised his wish for his client to be able to recognise choices in his life and take responsibility for himself and the choices that he makes. He perceives that such a realisation is the aim of existential therapy. In addition, clients are seen to also have the responsibility of the course of therapy, meaning that they should *'take the lead'*.

'I think my goal and my wish for client is they be able to recognise choices in life and take responsibility for themselves'

A.

'I believe that my client has ultimate responsibility in their life and therefore in therapy as well where they want to take therapy'

A.

Working with the existential givens inevitably involves working with mortality, death and *'awareness of time limits'* as participant C stated. For participant B it was her genuine interest in making sense of death that led her to seek a job within a palliative care context.

'as an existential therapist I suppose you know well what took me in was by death obsession if you like and how it's dominated my life and my being and so I've always been seeking to understand it. And how I relate to death and I guess working with other people's relationships with death and who are close up to it is one way of seeking further understanding'

B.

The personal is consequently impacting upon the professional and participant B presents her personal journey which seems to include an integration of the two.

Existential therapy involves working with *'Loss of health and death'* (participant D). It addresses issues arising from cancer and can be seen as an opportunity to understand death and mortality. It is therefore necessary for the existential practitioner to have the strength and courage to work openly with those issues. Participant E also refers to the therapist's wish for his clients to become autonomous human beings.

'And I don't shy away for example talking about dying or death or people wanting to be what they are and wanting to be themselves and kind of autonomous beings'

E.

'I kind of recognise those issues for people and not shy away from staying in quite a kind of difficult painful areas for people. So stay with those issues for people and not hide away behind a model, and that's probably how that comes in for myself'

E.

The participant offers an additional characteristic of the existential therapy as an approach that whilst lacking specific techniques '*exposes*' the therapist to those big issues. He continues by recognising the therapist's courage as a personal skill and at the same time claims that it is part of the job.

'I think that's my particular strength to do that, I don't shy away from big things or embarrassing things or scary things, it is sort of one of my strengths, that part of my work'

E.

Another element of the existential approach that arises from the participants' accounts is '*working with the world view of the client*' (Participant D). The therapist attempts to understand the client's condition by understanding his worldview. Participant D explains her way of conceptualising the client's situation by looking at the four dimensions of human existence: the physical, the social, the psychological and the spiritual (van Deurzen, 1984).

‘Well with the existential approach as you know, you’re looking at their full world as well, their home life. What’s it like at home. A lot of it is so straight forward you don’t even think about it. It’s really just picking at, you can see it when you look at the overall view of it’
D.

Exploring the client through the four worlds according to participant D can give the therapist a better understanding of his condition, a more holistic view of his situation and how he makes sense of the world. A phenomenological stance as it would be explored below would involve *‘looking at the whole picture’* the client’s whole world, trying to make sense of it and trying to make sense of how the client is making sense of it. The participant sees the content, processes and experiences of her client as being of equal importance. As she says: *‘The whole thing is linked, it’s all linked’*.

1.4 Therapists' attitudes to therapy

Participant A presented a very important characteristic of the existential - phenomenological approach. When the therapist approaches the client he attempts to eliminate any power dynamics and stresses the importance of human interaction between two human beings, the therapist and the client.

'I think in terms of building my relationship with the client, I see the client as an equal and I see them equally struggling'
A.

The participant adopts a phenomenological stance in his way of working, paying attention to the client's attitude and presenting issues and seeing the client as a human being who struggles in life in the same way the therapist does. The participant therefore does not approach his client from an expert's vantage point but chooses a more humanistic way. Client and therapist are therefore seen as equal.

In this subtheme, attention was paid on the way the therapists approach their clients and their attitude towards the therapeutic process.

'I pay attention to (...) how the client is presenting, what the client is presenting (...) my goal if you can talk about goal, I obviously I ask the client what their goal is what they want to take away from therapy'
A.

Participant A claims to consider in her practice the content as well as the way the client is presenting in therapy. This quote also illustrates the therapist's non-directive attitude, letting the client take responsibility of the direction of the therapy.

The participant also recognises that he holds his own wishes for his client. He sees himself as a ‘space-provider’ a facilitator that assists the client to achieve whatever they wish for themselves.

‘I think my goal and my wish for client is they be able to recognise choices in life and take responsibility for themselves and I don’t want to take that away from them so that automatically impacts how I am with them and you know... I cannot be there sort of direct them into this avenue or go down this avenue or focus on something in particular if I believe that my client has ultimate responsibility in their life and therefore in therapy as well where they want to take therapy... so yeah by giving space by allowing to sort of be in charge of therapy...you know you follow your client rather than direct them or lead them to a certain down a certain road for example.
A.

*‘I: So allowing the client space to follow their own path...
P: Yeah yeah I see my role rather more as facilitating and helping the client become aware that you know there are choices that can be made and only them only they can be responsible for making those choices and nobody else’*
A.

The therapist respects the client’s autonomy by allowing her, to grow into her own decisions. The client leads and the therapist follows playing the role of the facilitator. Participant B describes her way of working in a similar way. She also adopts an open attitude that allows her to follow the client and at the same time allows the client to lead.

‘That when I sit with a client I try to be as open as possible to go off where they lead me, down which path they lead but always I suppose opening up their world and how they see the world’
B.

In order to allow the client to open up, share her thoughts and experiences the therapist needs to also be open, adopt an un-biased stance and be willing to follow the client wherever he wants to go.

'So about being in the world and seeing people not as discrete individuals but always in relationship to the world and the people in it'
B.

'And I think existential thinking goes against that, it's very broad, it's very open and sort of openness is key so for me it's always Heidegger, the clearing in the forest you know'
B.

*'I: How does it come into your practice those existential ideas?
R: I think they come to my practice is that - I think you know it just does. I often - although I know about different models and this and that but I just follow really people's lives and the core issues that people bring.'*
E.

Participant E added an additional element to how she as a therapist approaches the client. The participant highlighted the importance of respecting the client's autonomy and her freedom to choose. She perceives the role of the therapist to be a supportive one, no matter what the client chooses for her life. She presents an example of conflict between what the doctor says and what the client wants. The therapist would therefore have to work with the tensions that evoke in her clinical practice.

'And we really recognise their own freedom to choose really who they are really and what they want in life, and I'm very much supportive of that and would recognise the doctor says this and that but really that's where your heart is and that's what you're wanting. I think I would in my practice just kind of very much go with the patient and go with where their energy is and that could be, let's say freedom'
E.

'The tensions let's say, here we are in the hospital and you need to say, "The doctor says this, the doctor says that." I very much recognise that the patient is their own self and they want to do this and that and not necessarily what the doctor says'
E.

Openness, flexibility and the phenomenological attitude were recognised as important qualities by the participants.

'I think those are very key words for me sort of closed and open and sort of always opening up. And I'm doing that with my hands but it won't be on your tape but you know that opening things up – that for me is absolutely at the centre of the work. So that's very broad.

I: So it's the whole individual, it's the whole world around them which you're trying to open up?

R: Yes. And it's a way of thinking; no it's a breadth of vision and interaction. And that to me is a lot of what existential thinking, its breadth and openness. Which sounds very general but it's key really. So that's sort of just a little bit'

B.

For participant B the aim of therapy is to open up the client's world and in order to achieve that the therapist herself should adopt an open attitude. Openness is at the heart of existential-phenomenological therapy. The therapist approaches the client with an unbiased, open attitude aiming to help her open up their horizons as much as possible and get a broader view of her life. Clients should always be approached with no presumptions as Madison (2005) claims regardless of whether they have a cancer diagnosis or not. The non- directive attitude is highly emphasised. The therapist leaves behind her wishes and expectations and allows the client to take the lead and guide her in his world. Participant C describes her work as a process of opening up areas that might have been closed for the client. New possibilities and options are being opened up and explored when working phenomenologically. The participant considers opening

up to be at the centre of the clinical work. While she was speaking she used her hands to emphasise the opening and breadth of the therapeutic work.

‘Where they might be closed – I might perceive them to be sort of closed in a certain area or a certain way of thinking. (...) I think those are very key words for me sort of closed and open and sort of always opening up. And I’m doing that with my hands but it won’t be on your tape but you know that opening things up – that for me is absolutely at the centre of the work. So that’s very broad.

(...) it’s a way of thinking; no it’s a breadth of vision and interaction. And that to me is a lot of what existential thinking, its breadth and openness’
C.

Participant D focuses on her way of preparing herself for entering the world of the client. She describes her process of ‘bracketing’ before each session. She stresses the importance of listening attentively and openly to the client without being influenced by her thoughts, concerns and personal issues. She acknowledges the difficulty of staying focused on the client for the whole duration of the session. As it is very important for her to remain focused on what her client is saying and not be interrupted by personal thoughts and biases the practitioner has found ways of drawing her attention to the client’s world by reading her notes before each session and thus forget her issues and enter the client’s world unbiased and undistracted.

‘ try not to think about my issues, to think about them [the client], to focus on them. It’s very difficult to do that for 50 minutes. But you do learn to listen, if you listen to people you get a lot more sort of acute and you just listen a lot more. Not think about my issues at all, focus on them. Read up my notes before I meet them. Make sure that I’m totally in their world. Try to be in their world, that’s how I do it now. Put aside my stuff.
D.

Phenomenology is a systematic method, as previously discussed, where the therapist puts aside her assumptions and bias and listens for the meaning something has for the client. The therapist tries to enable the client get a better perspective of his life, make sense of his worldview by attending, noticing, describing and not explaining. The phenomenological approach of the existential therapy attempts an unbiased grasp of the client's subjective experience (van Deurzen, & Adams, 2011).

'You're still sort of working with the world view of the client. You're still sort of working phenomenologically with the bias and the rest of it. But at the same time you're taking it a step further. You're actually working through a problem like what's the problem? What would it be like if you didn't have that problem? What would it be like if you...? You know, it's a systematic way of working'
D.

'just go with the patient really and see what the individual presents'
E.

Through phenomenological exploration clients can develop a wider perspective of their lives and discover new possibilities. Participant B adds another dimension to the existential-phenomenological perspective by claiming that it is not only an approach but a way of being.

'as an existential psychotherapist it's about not just how you see your patients. I mean your existential outlook if you like informs everything doesn't it. It's about it informs how you are in the world and how – and your own living and dying'
B.

Allowing ample space is for the participant a way of working existentially; and the aim of this space is to give the client the opportunity to explore her life in all dimensions. In the same lines, participant E allows space for exploration of the client's issues but at the same time acknowledges the limitations that present in their lives.

'Allowing space but also acknowledge'
E.

Participant E expresses another possible goal of therapy, helping clients acknowledge where they are in life and stay with that. Acceptance is therefore very important in which case the client is not forced to make a change but rather acknowledge his condition.

For participant F existential therapy is about *'being there'* for the client. Most therapeutic approaches use techniques and aim at creating changes in the client's life. From this vantage point, being there for the client is equally important and in some cases the only thing that is needed.

'The best you can do is just try and stay solid and constant and be there for them, you know, and allow the person to feel that you are there for them. You're not there to do anything, any investigation into them... it's very personal'
F.

'Being there' for this participant requires being *'solid and constant'*, making the client develop trust without putting any pressure on them. Participant F in similar lines to participant A above, states that the practitioner cannot have a particular strategy when working with clients. This means that therapy is immediate, the practitioner often

doesn't know what to expect and should not expect anything. The element of openness and holding an un-biased approach to therapy is highlighted and very significant participant F.

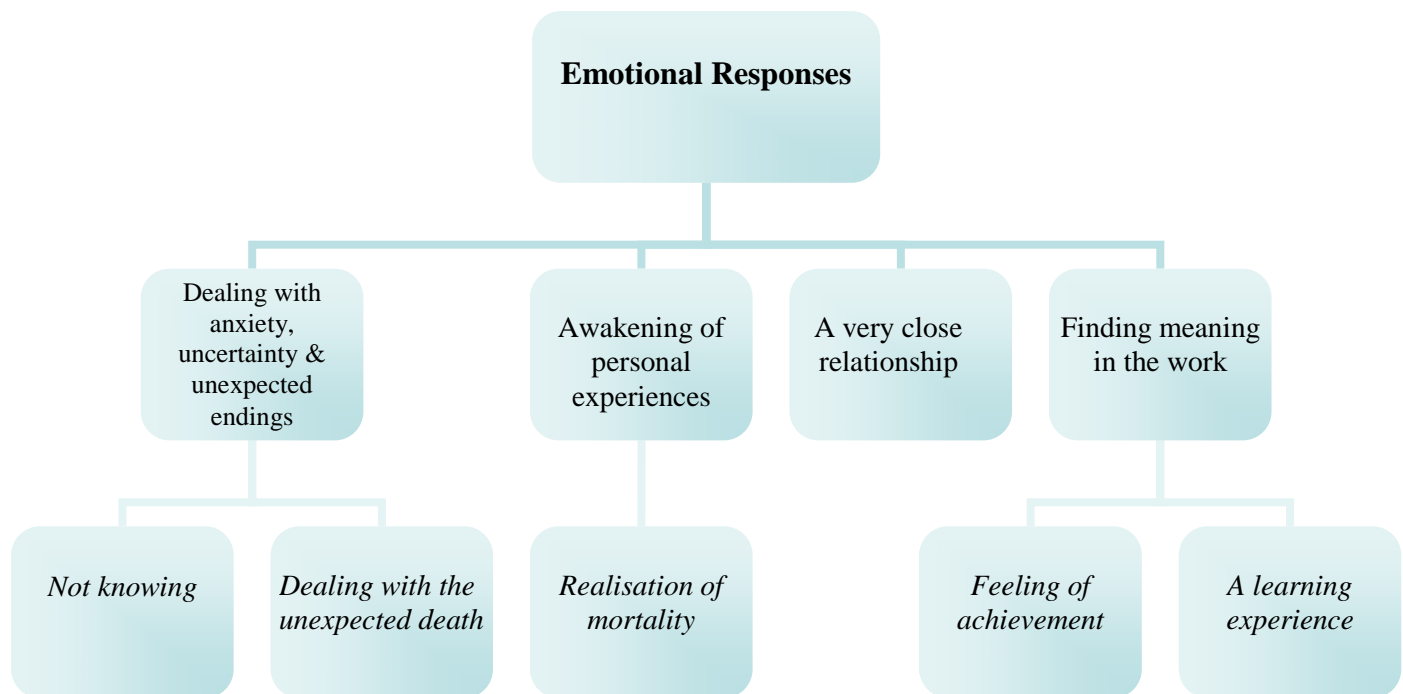
'you can't have expectations about what you can do and it is very, very immediate, you can't have any strategy that you go in with'
F.

Lastly, participant F introduced the role of the body in therapy. He claimed that paying attention to his own bodily reactions during the process of therapy can be a useful source of information. Similarly, paying attention to the client's body, the non-verbal communication as well as the verbal, can offer a more holistic approach to understanding.

'I've also become much more aware of the unspoken and the non-verbal dimension in therapy and what is happening to me in a physical way that I wouldn't have particularly taken notice of years ago. I've become much, much more focused on listening to my own body. That's the best way I can put it really, listening to my own body. But what I would say, put it this way, that listening to the client becomes a whole body experience rather than something that is concerning my ears and that I also believe that what is said and not said by the client is a response to the quality of listening rather than the other way round. So it's how you listen invokes the comment from the client, not the other way round'
F.

The participant also states that it is later on in his career that he acknowledged the importance of paying attention to his body or that he managed to focus on it during the therapeutic encounter. He believes that listening to his own body affects the whole listening process something that he considers to be impacting upon the therapeutic relationship and the way the client feels and responds.

2. Therapists' emotional responses to working with clients diagnosed with cancer



Overview

While trying to make sense of the participants' experiences, their feelings and emotions emerged in relation to working with clients affected by cancer. The emotional impact of the work upon therapists was explored revealing feelings of anxiety in relation to the uncertain clients' future, distress due to the unexpected death of a client and a general feeling of '*vertigo*' in relation to working with clients suffering from cancer. The word *vertigo* illustrates the experience of sudden changes, the anxiety and fear of not knowing what will happen next.

Undeniably, therapeutic work is a close, intimate relationship very often unique in its nature. This subtheme explores the participants' emotions in terms of working with

clients affected by cancer. It is obvious that participants have been affected themselves from the presenting issue and several feelings and emotions arose. Lastly, the therapists' experiences revealed several personal issues such as memories, similar cancer related experiences, personal losses and the therapist's realisation of his mortality that arose from the process of therapy. Those sub-themes will be unpacked and explored further below.

2.1 Dealing with anxiety, uncertainty and unexpected endings

Working with clients diagnosed with cancer was a difficult experience for some of the participants, emotionally very demanding and unpredictable. Therapists are expected to hold their clients' feelings of uncertainty as well as their own. Unexpected death is not uncommon when dealing with cancer. Therapists are often faced with the loss of a client and the feelings that arise from such an event. Participants attempted to make sense of this experience as well as their associated emotions.

'I mean, I think, you know it's emotionally very heavy. It is very very demanding. So sometimes more than others so I mean at the moment I've got two patients who I've been working with for three and four years who are now getting towards the end and they're getting more sick and probably the prognosis is not very long. So that's you know very hard'
B.

Participant B claims that work is emotionally very demanding. It is becoming even harder when the client's prognosis is not long. Cancer is often an unpredictable illness with ups and downs and therapy with a client diagnosed with cancer can be an emotional rollercoaster as participant B describes it.

'It's a real rollercoaster'
B.

'So a real mixture and an intensity of emotion, obviously, huge sadness and loss'
C.

Feelings of sadness and fear arise for clients. Therapists find themselves in a similar situation, slightly more difficult than usual practice. Participant F described the experience as ‘*vertigo*’ a very strong response to the unknown.

‘it’s a bit like standing on a diving board or on some rocks on a cliff which are a little bit higher than you want to jump off from and there’s that sort of fear, almost like a vertigo, that you get before you jump, and it’s like that but in a very small micro way. But there’s something about it that just gives you a sense of almost vertigo about life’
F.

He also stresses the impact the client’s illness has upon him, feeling brutalised, contaminated by the illness too, a very strange and powerful experience.

‘But there’s also something quite difficult about engaging with somebody who is really, really ill and what it does to you, that it almost brutalises you, that you almost become contaminated by the illness. If you become that sort of empathic and engaged with them, it’s almost when you come away and you kind of feel that you’ve been touched by it yourself, it’s really strange’
F.

Looking more closely at the feelings arising for participants there was an element of anxiety expressed by participant A. This anxiety could have been due to her being a young practitioner with limited experience of working with a client with cancer.

‘I think there was an element... of anxiety from myself in terms of being with her because... she hadn’t been given the ‘all clear’ they also haven’t told her how long she would have left or whatever it was just you know the stage she was at where the possibilities could have been infinite’
A

The participant becomes aware of her feelings of anxiety, something that seems unusual to her. She claims her anxiety to be based on the fact that the client hadn't been given the 'all clear' therefore the possibilities for her surviving or not were uncertain. It was therefore the 'not knowing' that caused the therapist's anxiety and possibly a fear of what might happen next.

'So now I was faced with someone who had to face up to the possibility of dying and for me that was the element of you know I'm gone have to let her go not knowing if she will survive or not of course you never have that with clients, client can leave the last session and gets run over by a bus you know the element of death is always present but with her it was so obvious'
A.

The participant upon reflection concludes that she has to stay with her feelings of uncertainty and work with them. She gets in touch with the reality of the situation that her client may not be coming back, may soon die and she will never know whatever happened to this client. This was a special case. Soon she rationalises by saying that actually we can never know when a client is going to die. Even though the uncertainty is always there it somehow feels different with the client with cancer as the possibility of death is much higher. The participant was encouraged to reflect more upon her feelings.

'I: So how was it for you as the therapist to sit there with the client facing possibility of dying?

R: I think that was... I think that was the most difficult bit... to sort of take her to the door, in the last session take her to the door shake hands and say goodbye and thinking.... I don't know if this woman will be around next month or next year... you know... and of course again you have that with all of your clients at possibility when you let them go but with her it was much more acute obviously much more immediate you know the....the possibility it wasn't something elusive somewhere in the background sort of you know be there... in a sort of.... Much wider possibility it was real it was

there and it could have been very very soon you know that was the difference'
A.

With a clear emotion participant A admitted that sitting with that uncertainty was the most difficult part of the work. Once more she generalises her thoughts to other clients making a more philosophical statement that nobody knows when the time will come. She recognises however the acuteness of her client's condition which explains the power of her emotions. The probability of death was in front of her, now it was real and not a philosophical argument. This realisation is believed to have caused her struggle and feelings of anxiety in being with a client affected by cancer. Towards the end she comes to recognition of where the difference lies with this particular client group.

Participant C had a similar experience when taking clients to the door and having to say goodbye. Realisation of having no control over or knowing what the future will be for those clients caused her feelings of great sadness and despair.

'I would often be left with, I had no idea what was going to happen to these people. You never knew whether they were going to live or die'
C.

'So I suppose that's the issue, I always, in those kind of situations ... I've said "Goodbye" and not "See you again". To have the end of each session, you never know whether you're going to see the person again, You can never be certain that a client is going to come back the following week, but particularly with cancer'
C.

The participant takes the issue a step further by choosing not to say ‘see you’ to her client but ‘goodbye’. This way she addresses the finite nature of the relationship reiterating it is coming to an end. More importantly she provides a closure to herself and lets the client go.

I: So it was all left up in the air and you didn’t have a proper ending. How was that for you not to be able to have a proper ending with her?

R: Well at the time I was quite green, young. So at the time it was hard to take that. So I took it to therapy and talked about it. Because I found it hard to let go of things at that time’

D.

Participant D assumes that her feelings of loss and sadness after losing touch with a client and not having a proper ending were due to her lack of experience and difficulty with endings. However, there seems to be a resemblance in the therapists’ feelings that have been on a similar situation. Even though young at the time she did have the maturity to recognise and take the issue to her personal therapy in order to resolve it.

Another very important element that impacts upon the participants is the unexpected death of a client. Participant B equalises the painful experience of a client’s death to hearing that somebody died. The participant sees her response as ‘a normal part of life’ we always feel sad when we hear someone died. She focuses more on the therapist being affected for instance not getting the proper ending therapy should have, rather than the devastating feeling of losing a client suddenly. This however is the raw reality of this kind of practice, a client might die suddenly without having completed therapy or having the chance to say goodbye.

'But you know then it's quite, it's always difficult when you hear of somebody's death and then you reflect. And certainly it may not be the ideal ending that you would like as a therapist to sort of finish as one does sort of normally in inverted commas, you know working to an end and with a client, it may not be like that with some of these clients'
B.

Trying to focus more on her feelings she claimed it is very difficult not to have a proper ending with a client. It is always upsetting for therapists not to be able to complete therapy '*as they ought to do*' even more in this case when lack of an ending is possibly due to a sudden death.

*'I: How is it not to be able to have that space for an ending with a client?
R: You know sometimes it's very difficult.
That was very difficult to hear that he had died, one wants to be able to sort of see it through with them if that's what they want'*
B.

The therapist also feels she hadn't been able to give her client the opportunity to work towards their death, come to an acceptance of their dying and be close to them.

Participant C who had experienced the sudden death of a client described it as '*heart breaking*'. Focusing more on this experience and the meaning it had for this participant it was obvious she was very much affected. The participant stressed the importance of being prepared for the death, as much as that is possible, and felt very sad when clients did not have the time to say goodbye to their families.

'I suppose I feel quite strongly I can't ... it saddens me when people miss out on the chance to say things to each other.'
C.

For participant B a sudden death of a client was the hardest thing to deal with in relation to her clinical practice. Reflecting upon her work with that particular client she felt being in the midst of therapy when the client dying suddenly left her feeling socked and exposed.

'I think the hardest thing for me as a therapist working with these patients is definitely when they die suddenly, And you know we were really in the midst of looking at her fears of dying and she was hoping ... And we were really in the midst of that work of how the struggle of you know "I could die." And then she did die'

B.

When the client dies suddenly the therapist is left hanging, shocked and experiencing a painful loss. The feeling of not knowing is still present thought slightly different. Having spent time working with a client's feelings and fears towards her death, not being able to be there for them when they pass away creates feelings of bitterness.

'there was no knowing how it had been for her. I hoped that she had a very close family so I hoped that they were all with her but you know so you're left with that not knowing how their fears were in relation to dying and your just sort of left really with that all hanging'

B.

However, participant D also had similar feelings of loss after suddenly and abruptly ending therapy with a cancer client. Even though the client's death was not the reason the therapy came to an end, the therapist struggled with similar feelings.

'I never had the closure with her. So I don't know what's happened to her. You know I honestly don't know what's happened to her. That was quite sad when, but you know you have to live with that sort of loss'
D.

Those experiences highlight the importance of having a proper ending in therapy even in the most difficult situations. Supervision and personal therapy appeared to be essential in most cases especially because of the nature of the therapeutic work. In particular, for therapists working with clients diagnosed with cancer it appears to be necessary in order to find support and cope with all those intense feelings.

'So there was a lot of ... very important to have a lot of supervision for the counsellors because you were left with ... I suppose the things I would often be left with, I had no idea what was going to happen to these people. You never knew whether they were going to live or die'
C.

In similar lines participant C expresses the need for supervision as bearing the unknown future of the client can be very difficult for the therapist.

2.2 Awakening of personal experiences

All participants identified personal issues arising while working with clients diagnosed with cancer. Several participants disclosed the realisation of their own mortality whereas others the awakening of their past personal losses.

The client's condition brought to the surface thoughts and feelings for participant A, of losing a relative to the same illness. The therapist's responsible decision to take her unresolved issues to personal therapy once more emphasises that on-going support is needed for therapists. Recognition of the complexity of this kind of practice in terms of the feelings arising for both the therapist and the client and the flexibility of boundaries required by the therapist was also an interesting finding. At the same, acknowledgment of the therapist's personal history related to the subject of cancer is paramount in order to be able to work unbiased. The therapist needs to find a way to work with her feelings and experiences in a way that she feels comfortable in order to avoid feeling stressed and be impeded of fully emerging in the therapeutic process.

'I actually can't remember whether I had ever talked about him in personal therapy before (...) but I specifically made it subject of my personal therapy because I was going through therapy with my client so it felt very very much important to me that I look at it in another context i.e. my personal therapy and explore it for myself and talk about it and bring it up and get a different perspective on it'

A.

The therapist got emotional talking about her experience of losing a relative to the same illness and how those feelings came back when she started working with this client. Her responses highlighted a difficulty in exploring deeply her client's issues. It is not uncommon to have clients who hit a nerve on us. The question is whether it is possible to completely bracket our feelings and biases or explore what it is we can do as practitioners if something bracketing is not possible. Exploring the experience of this particular practitioner led to a blurring of her personal experiences and the impact of her client's condition upon her. For that reason it is difficult to identify what exactly affected the therapist; her unresolved issues or the client's condition or both.

'I was affected by it there is no denying by I didn't I think I wanted I needed to and I was very careful but the whole process was not going to be about me and you know coming to terms with my own issues....and the guilt that was attached to it you know so ... it was there in the back role and I didn't want this to enter the therapeutic space and I think that stopped me from sort of fully emerging myself into the process with all my being, being there for her I was afraid that that it would end up being about me rather than being about her and her life and her cancer'

A.

The participant's decision to take the issue to personal therapy showed her recognition that this was still unresolved. Even though the experience was not an issue for her prior to meeting the client, it was awakened when the therapeutic work begun.

In addition to her anxiety regarding the client's future, the therapist had to face her fear that in the case she didn't '*bracket*' enough her feelings therapy could end up being about her rather than her client. This was a very interesting statement that explains her difficulty to fully emerge herself into the therapeutic process.

In relation to this, participant D recounts her experience of awakening losses and bereavement. From her experience it was evident that work became hard when personal issues were involved and at the time she seems to have struggled to bracket effectively her own issues. She suggests that training should be focusing more on helping the therapist recognise what his own issues are and attend to them.

'It's very difficult to do that when you've got your own issues. It is difficult to work with that. But with your training you should be able to sort of push it aside a lot more'
D.

The participant also suggests that the therapist needs to detach herself from those feelings as much as possible in order to be able to fully engage with the client. Those feelings and experiences are felt as a possible obstacle to the work requiring the therapist's attention.

'Once you put aside your feelings, you've got to detach from your own sense of loss because it reminds you, it always reminds me of people I've lost in my life through cancer and stuff like that. My dad died of lung cancer. And once you can sort of divorce yourself from that and work with their issues and try to be more objective. It's very difficult to do that when you've got your own issues ... It is difficult to work with that'
D.

In order to achieve unbiased openness and phenomenological exploration of the client's accounts, the therapist needs to 'bracket' her thoughts and feelings. Participant D tries to focus on the client, entering his world by reading her notes before the session, listening attentively to her client and block out her concerns.

'I try not to think about my issues, to think about them, to focus on them. It's very difficult to do that for 50 minutes. But you do learn to listen, if you listen to people you get a lot more sort of acute and you just listen a lot more. Not think about my issues at all, focus on them. Read up my notes before I meet them. Make sure that I'm totally in their world. Try to be in their world, that's how I do it now. Put aside my stuff'
D.

A different kind of anxiety arose for participant E and was health related. Working in a hospital environment brought to mind a past health trouble.

'when I started working here I had a very strong reoccurrence of that anxiety.. So I had all those sorts of thoughts around that. I had lots of health anxiety thoughts and feelings.'
E.

In order to relieve her anxiety, the participant had the necessary health checks to ensure she was healthy and be able to focus on her clients rather than worrying about her own issues.

'But I felt if I didn't do it (have checks) at the edge of starting of this job I don't think I'd be able to work in here, I think I would have been too anxious, too preoccupied with my own health to work with people. And I think that at the moment I feel reassured and I've been for my check and stuff but I think what happens is that you get a little bit desensitized... So there is a level of denial really about your own health, but I think it's just a matter of time before this anxiety comes again and I will be a little bit more hyper with it again and will need to go and check again'.
E.

The participant feared that this anxiety can become on-going and possibly reoccur in the future meaning that she will have to repeat the tests in order to ensure she is healthy and

relieve her anxiety. She believes this was the strongest impact this kind of practice had on her, awaking a fear that she may die of the same illness leaving loved ones behind.

'maybe that's what will happen for me in this job that I will kind of get a little bit more anxious, I will have to get something checked and then will go underneath the anxiety, hide a little bit.

I: So what sort of anxiety do you think it is? Is it related to the job that you do, that you have to face cancer patients every day?

R: No I mean it is around having cancer myself and then possibly - I mean this is kind of convoluted isn't it because it is sort of around having cancer myself and then sort of having to step out of work and having treatment and potentially dying...On the other hand I think there was a sort of spell of time that I was more anxious and now I'm not so anxious but then I'm sure I'll be more anxious again'

E.

Even though the participant claims that her anxiety is not related to her work, it seems it is the working environment that awoke her fear of getting cancer and dying from it.

Participant F also felt he got in touch with his own mortality through working with clients affected by cancer.

'I suppose the big impact it had on me, there were two ways in which it impacted on me, was it inevitably got me in touch with my own sense of mortality.'

F.

Elaborating on his response the participant through his practice realised the fragility of human beings and identified his fear and anxiety of developing an illness that can be fatal.

'So it freaked me out a bit to be honest, and I mean I was around quite a lot of death at the hospital, so the whole idea of the frailty of the human body and how easy it is to get cancer, to have a heart attack, you know, basically to get some terminal condition'
F.

Being close to terminal clients is definitely an awakening experience. In this case, the participant claims to have accepted his mortality and now wonders what will be the cause of his death. Reaching that level of acceptance it is not always possible nor for everybody. Therapists working with clients affected by cancer might often find themselves in the position of having to work with their feelings towards their mortality and the uncertainty life entails.

'I think I just...I think one of the things was that as I became more and more aware of my own mortality and the possibilities of my own death...I've reached a point in my life where I'm very aware of my mortality and I think I wonder what will actually take me? Will it be cancer? Will it be a heart attack? Will I drown in the sea? Will I have a road accident?'
F.

Even though one might be able to come to an acceptance of their temporary nature, they might always have the feeling of incomplete businesses, wanting to live more and having more to do in his life.

'I keep sort of thinking about that Woody Allen comment about death, that I'm not afraid of death, I just don't want to be there when it happens and I must admit that that is so true for me now. However much I say I'm coming to terms with my own mortality and that there is a huge part of me I know hasn't really felt they've completed their life enough to allow myself to go there'
F.

Participant C in similar lines came to a realisation of the importance to appreciate every moment in life.

*‘we just never know when we might die, when we might become ill. When I’m worrying about trivia, just to remember that and appreciate health’
C.*

This quote also shows that therapists tend to incorporate the philosophical values of their chosen approach not only to their practice but to their lives in general. Here the therapists reminds himself to live in the present and reminds himself of her finite nature.

2.3 A very close relationship

Even though material from this sub-theme could have been incorporated in the previous ones, it was thought to be of great importance and value and possible to stand on its own. The therapeutic relationship is undeniably a very close one, intimate and on several occasions unique. Participants' responses when talking about the relationship with their clients were moving and emotional.

Participant A struggled to find the words to describe the relationship to her client. Even though she did not want to sound too emotional, there was obvious emotion representing the closeness of their relationship.

'I had a great relationship with her...but in terms of the relationship I think... her, she was one of the clients that death and the... without wanting to sound too emotional...there was an element of love there. It was a solid, good relationship, a very... we felt comfortable with each other... she became comfortable in sort of showing much more emotion, she cried and you know in the way she disclosed I think...it just became deep and deep as time went on I just I loved being with her I was looking forward to our sessions. See I think the relationship was very very good'
A.

The participant also illustrates what a good therapeutic relationship means to her; feeling comfortable with each other, showing and sharing emotions which led to deep therapeutic work. Participant A later on discloses her wish for this particular client to survive her illness and go after her dreams.

'I was emotionally much more attached to her in wanting this [wishing her well for the future, achieving what she wanted in life and following her dreams] for her than I was... than I ever have been with a client'
A.

For participant B what makes this relationship so important and intimate is the sharing of fears and death. Talking about the fear of dying brings the therapist and the client close in a relationship that is not common. She compares the therapeutic relationship to the one a woman has with a midwife, linking the beginning and end of life. The struggle of accepting death, fear and anxiety are shared between the two human beings.

'I: Sounds like it is a very important relationship for both the therapist and the client?

R: Well I suppose you don't get much more intimate situation than sort of facing your own death and facing your fears and a relationship with death and birth is the other one that comes to mind immediately when I think you know when I say those words and thinking of the close relationship one can have with a midwife. And you (...) come through the struggle with them'

B.

Participant C raises awareness of the need for a humanistic attitude, viewing the person as a human being, without having an aversion by the illness. The closeness one can experience with someone in a non-judgmental environment shows the quality of the therapeutic relationship.

'ultimately I think it's the quality of the relationship, being able to be there in the place and whatever. The individual person rather than a cancer patient'

C.

The therapeutic relationship however is not always so easy to neither establish nor maintain. Working within a hospital setting with clients going through a life changing experience, suffering from an illness that can be fatal and struggling to make sense of what is happening to them can close them up. In such cases, clients may not want to participate in therapy, claim nothing can help and no one can understand them. As participant F states the client can be very unpleasant so the therapist should genuinely want to approach this person, be particularly interested, willing and persistent. The participant recognizes and respects the client's hesitation and shows that this kind of work has great meaning to him even when he is not welcome by the client.

'It can't be glib, it can't be, you know, disingenuous, it has to be meant, you have to genuinely want to know about this person. And sometimes you're trying to get to know somebody who is quite unpleasant to you, who really is doing their best to tell you to go away, or they have this thing that they don't want to show emotion, they don't want to get close to any emotion. There is a fear that with you talking to them they're going to become emotional and to be honest a lot of people do become quite emotional they start to talk about their fear'
F.

Participant F expresses his empathetic attitude by recognising and respecting the client's difficulty and wish to avoid getting in touch with their painful emotions. This can be a difficult situation the therapist has to face which possibly brings up a wide range of emotions for the practitioner too.

2.4 Finding meaning in the work

From this super-ordinate theme a paradox emerged. Even though participants claimed there are several difficulties in working with cancer clients and a wide range of negative feelings arising for the therapists, they also claimed that it is a very rewarding work and a learning experience for them.

'It's not just all about blackness and you would think "Oh this must be unrelenting working in this kind of the black context of death and the grim reaper and all the rest of it'
B.

From participants' accounts it emerged that they were able to create meaning through working with clients diagnosed with cancer and the issues arising for them. Working with death, sickness, anxiety and uncertainty can be very difficult and feelings of loss and helplessness are not unusual for practitioners. Working with clients affected by cancer however, seemed to be a learning experience as well. Participants claimed they were given the opportunity to be close to death through their clients' experiences and learn about the ultimate unknown, death.

'I suppose the satisfying if there is. If there's something that's satisfying or gratifying in it is of course the helping them to reach sort of realisations and some kind of coming to terms in some way'
B.

Participant B gets gratification from this work as she helps clients come to realisation and acceptance of their condition. Working with clients diagnosed with cancer satisfied several needs for participant B. As she claims she had a genuine personal interest to

understand death all her life, having ‘*a death obsession*’ as she describes it. Wanting to find answers led her to choosing this context of practice hoping she will gain some better understanding.

‘I mean as an existential therapist I suppose you know well what took me in was my death obsession if you like and how it has dominated my life and my being and so I’ve always been seeking to understand it. And how I relate to death and I guess working with other people’s relationships with death and who are close up to it is one way of seeking further understanding’

B.

The participant feels she learns a lot from her clients. Therapy seems a dual process where therapist and client both learn, develop and gain something from the process. The participant here generalises using ‘we’ referring to all therapists. In particular, she claims that through practice therapists also work through their understanding of life, relationships and themselves. Consequently, in a way she views practice as a means of personal development for herself as well as for her client.

‘Often of course as therapists we are working through our own aren’t we, our own understanding and I (...) It furthers our own understanding of life and of people and relationships and ourselves’

B.

‘*Learning*’ also refers to learning about death. The participant hoped at the beginning of her practice for a ‘*eureka moment*’ a moment where she could make sense of what death is. This search for answers possibly led her to choosing to work in palliative care too.

'So therefore in looking at death all the time. I mean I – I suppose I wanted to know more about what death is. I think when I started this job I thought "Ah there'll be a eureka moment and I'll..." And I don't know if I see on some subliminal fantasy level I think I thought "I'll know what death is."
B.

However, death is the ultimate unknown. We can never really know death. The participant came to realise that through her practice. Nevertheless, working with clients close to death was a learning experience as she was given the opportunity to get some understanding of 'what death is' even though it will always remain a mystery.

'And it is true I know more of what death is but there's more and more mystery. It just keeps on opening up'
B.

The participant was encouraged to reflect further on this learning experience, what was it she was looking to understand and what she eventually came to realise.

'I: In what way you wanted to understand death? What were you looking for?
R: I think I wanted to – I certainly wanted to understand more of what death is. And I've seen lots of things of what death is but ultimately we don't die until we die. So of course we never know what death is until we die and even then we don't know what death is because we're dying and not dead. So we can only ever know dying and that can only ever be through our own dying. So it's the ultimate unknown and the ultimate mystery isn't it'
B.

Her curiosity and possibly fear led her to this kind of practice. Even though human beings cannot learn death but only dying, being close to death seemed very important for

her, in order to get some answers to her philosophical questions. Learning about death meant learning about life.

'But you can touch upon it. And maybe there's something in my curiosity and my – that I've always had a sort of curiosity of being and that death is the ultimate thing to be curious about, the ultimate unknown when you touch upon death and others experiences of death and you witness death and you're touching on something more supremely unknown and mystery and can never be known and that's huge it's – that is being with a capital 'B'.

(...) It is – it just opens really what you are thinking and you are feeling, what life and death is'
B.

For participant D learning occurred not only with regard to death but also in terms of clinical practice. Working with clients diagnosed with cancer was very difficult work as she claims, but one that taught her a great deal about herself and her clinical work.

'when I did get in to it [working with cancer clients], it was very interesting. I learnt a lot. And it was very interesting. I learnt a lot from it, I learnt an awful lot from it because it was difficult'
D.

For participant B helping clients come to terms with their predicament gave meaning to her work. Often this is one of the goals of therapy and if it can be achieved it offers a sense of relief and achievement to both client and therapist.

It might be assumed that working with clients with cancer, facing their mortality could be black, depressing and doomed. Participant A points out the paradox that working with death can also be lively.

'A lot of the work that we did together it was very lively, it was full of kind of he had a very strong sense of humour and we laughed a lot. And the palliative care meetings made me laugh and I think there's a care in that really'

A.

Following a very existential attitude, participant B claimed that being so close to death can actually make individuals appreciate life even more. As Yalom (2008, p. 7) writes *'Though the physicality of death destroys us, the idea of death can save us'*. The participant came to this realisation through her clinical practice. Death, the realisation of death adopts a different more positive meaning. It is the means to a more fully lived life where small moments of happiness can be appreciated.

'Because of course when you're up against death it throws a different light upon life and the joys that you experience in life from just stepping out into the summer's morning and the sun on your face or that cup of coffee. You know it becomes very – it can be so much sensation can sort of come alive in so many ways'

B.

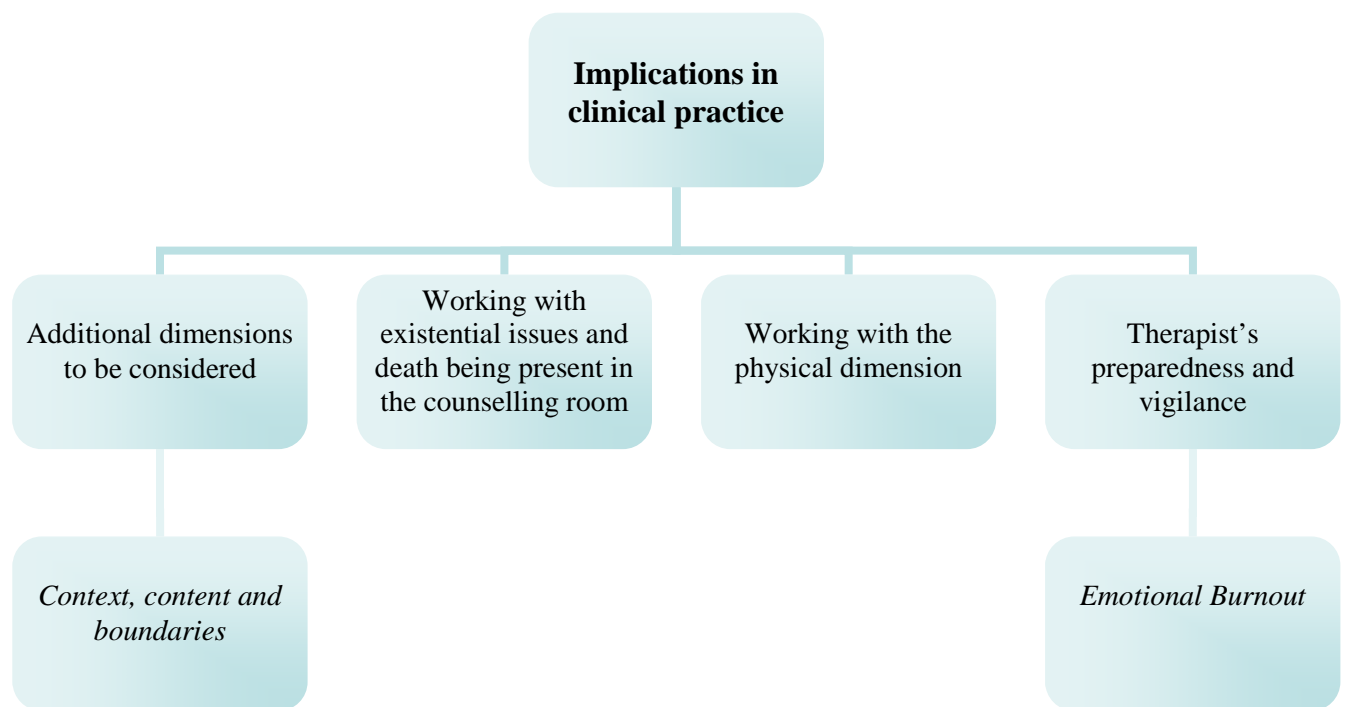
Lastly, for participant E working with clients affected by cancer was a slightly different learning experience as she found out more about cancer itself. Cancer is often perceived as a death sentence however, the clients' experiences taught her that a high number of patients can be successfully treated and survive.

'But I think that the convoluted bit about it is that actually from this job I've learnt that actually a high number of cancers are quite successfully treated and I didn't know that before because in the culture out there the message is that cancer is deadly and you die and that's that, your death sentence'
E.

3. Implications in clinical practice with clients diagnosed with cancer

Overview

In addition to the emotional impact of this kind of clinical practice, it was considered important to pay attention to the context and content of the work. Participants claimed there are several deviations in terms of what is considered usual psychotherapeutic practice and work with clients affected by cancer within a hospital environment. Those deviations included differences in context, boundaries and frame of therapy and require a more flexible approach from the therapist.



As it emerged from participants' accounts, several existential issues arose for clients who have been diagnosed with cancer. Therapists were expected to work with issues such as isolation, meaninglessness, anxiety and death; the elephant in the room. Working with death can possibly be a great challenge for many therapists. However, when working from an existential perspective, death is part of the client's condition and cannot be disregarded.

In order to explore difficult issues such as the ones mentioned above, therapists need to have them explored within themselves first. From participants' accounts several other suggestions emerged with regard to the requirements of this kind of practice.

3.1 Additional dimensions to be considered

While exploring the experience of working with clients diagnosed with cancer a question arose regarding whether this kind of psychotherapeutic work was any different from work with other client groups.

There was a paradox arising from the exploration of participant A's experience. Even though participant A claimed that there was no difference in his clinical practice, from the analysis of his experience there seemed to be deviations from what is considered usual practice. Exploration of participants' experiences showed that there are several implications in working with clients with cancer as it will be presented below.

From the analysis of the interviews it becomes evident that in terms of existential practice the therapist's way of being with the client was no different than with any other client. This refers to their phenomenological openness in approaching each client as a unique, individual human being. The therapist's attitude towards the client was therefore no different but the client's facticity and particular circumstances had to be acknowledged. The characteristics of clinical practice with clients affected by cancer as presented by the therapists' responses will be identified below.

Participant C highlighted that she does not differentiate between clients with cancer and clients without a cancer diagnosis. She places her attention upon the therapeutic work's time frame and context as well as meeting the client's needs. She therefore adopts a

phenomenological attitude in her approach to clients, respecting individuality and avoiding assumptions.

'I suppose the way I work would not be based on whether they had a cancer diagnosis or not but more about other things – the timeframe within which we're working, the context in which we're working, the individual's needs / wishes / desires from the therapy'
C.

Clinical practice with clients diagnosed with cancer usually takes place within a hospital environment. The setting as well as the client's poor health and regular treatment intervals may impact upon the therapeutic process. There are a lot of extra dimensions that therapists need to consider.

'There is a whole extra dimensions to in-patient work about how you see that patient when they're in the bed, whether they've got a side room or whether they're on the ward? Do you draw the curtain? Do you not draw the curtain? How do they want – how do they feel being seen on the ward? Do you see them as family members, not family members? There are so many variables.
I: Very different kind of work?
R: It's very different work.
I: Unusual.
R: Yes. You don't have your well defined space and your 50 minute/hour always, sometimes not at all'
B.

Participant B is being bombarded by internal questions wondering how to respond to this exceptional context. She recognizes the many different variables that usually therapists in private practice or working with other client groups do not encounter. She needs to adapt to the context, find a way to create a safe environment for the client under difficult conditions and at the same time feel comfortable herself within it.

Yalom (1983) distinguished between outpatient and inpatient group psychotherapy claiming that the inpatient groups require 'a shift in the therapist's time frame' (Yalom, 1983, p.106). He considers the life of a group to last a single session; longitudinal work is therefore not possible.

Duration of the work and frequency of sessions can also be disrupted when working with cancer clients and especially within a hospital setting. Clients might not be able to commit to the usual once a week therapy and the length of therapy may be difficult to arrange. Therapists once more need to be flexible.

'So some patients we might see a year or two years or even you know some patients I've got sort of three or four years I've been seeing them. And that doesn't necessarily mean weekly, it might mean weekly at one point when they're – you know say at diagnosis or re-diagnosis. Certain sort of crux moments and then they might go to monthly or they might have a period out from therapy then represent.

I: So you're quite flexible according to their needs?

R: So you're really going with clinical need in terms of where they're at in terms of the disease and how they're coping with it'

B.

For participant B the nature of this work is very individual. There are no strict policies and contracts applied to all clients. Therapy is tailor-made to meet each client's needs, depending on the stage of illness and prognosis. Therapists are required to follow medical needs rather than psychological, but also keeping in mind the client's response to her condition.

'I: So it sounds like very different from the classical therapeutic environment and relationship and everything?

R: Oh absolutely, yeah, absolutely because... Well, you see the thing is you don't have the regular frame... the only containment that you have at all is what's taking place between the two of you'
F.

In the absence of a safe therapeutic frame participant F claims that the relationship is what contains the client and the process. This is probably what makes this kind of practice possible and effective. The closeness of the therapeutic relationship as it will be explored below is very significant when working with clients suffering from cancer and the terminally ill. Efficiency and high level of activity are necessary qualities for the therapist working in such conditions (Yalom, 1983).

Smith-Pickard (2004) writes that the experience of providing therapy in the wards of hospitals, to acutely ill clients, is the greatest challenge of the therapeutic frame. The traditions of therapy can look absurd in such a context. Participant F stresses that the most important element in this kind of work is not the frame but the encounter between therapist and client.

'working in a hospital that can be really difficult because although you've got the curtains drawn round you if you're on a ward and you're talking to somebody, you know, it can be a very sensitive moment in the work that you're doing with this person and all of a sudden some nurse or some young doctor is going to come in and strip the curtain back, assume that you're a relative and come and talk straight over the top of you and...you know, and it's "hello Mr So and So, and how are we today?", you know, and you feel like saying look just get out of here, you know, piss off, we're in the middle of something'
F.

Participants experienced this disruptive environment very difficult. Even though the therapist does his/her best in order to achieve a safe environment, often there are

inevitable intrusions by medical staff or family members. The therapist is then found on the difficult situation of having to deal with the interruption, look after and protect the client's privacy and confidentiality and at the same time deal with his/her feelings of anger and frustration.

Participant F also stresses that therapy in those circumstances can last for only a few sessions. Each session therefore is of great significance as it could be the last one. This causes great pressure on the therapist who feels the sessions are becoming very intense. In addition, there might not be the possibility to attend supervision in between sessions so the therapist might feel that has to stand on his/her own feet and proceed in the session the best way he/she considers useful for the client.

'You're only going to see these people once or twice, so we're talking about very short encounters, but it's intense. So it's not as if you've got time to go to supervision and come back and see them again or anything like that. I mean we used to do immediate supervision with each other quite often, especially if it was something quite traumatic'

F.

For participant F peer support was important in those events. Therapists working in those settings might often develop peer supervision groups in order to support each other and deal with the unexpected events and disruptions happening during their clinical practice. The participant drawing back from his experience uses strong words to describe those events occurring in his practice.

'But, yes, it was...I was having to deal with the impact on me, that's what I took to my peers with these sort of instant supervisions, because we were

sometimes quite traumatised and brutalised by what was happening in the hospital'
F.

On occasions where therapy does not take place within a hospital environment but in a generic counselling service, challenges might still appear this time due to unhelpful policies that intervene with therapy. Even though policies and boundaries are in place in order to protect clients in this case the therapist felt she needed to reconsider. Participant A proved to be flexible and challenged boundaries and service policies in order to meet her client needs.

'Normally we have cancelation policies whereby if clients cancel for four sessions or whatever you have to terminate and you have limited freedom within that but with her it was absolutely fine I sort of argued my case and it was fine'
A.

Meeting her client's needs, respecting her inability to attend therapy and respecting her wish to continue therapy, the participant argued and succeeded in making an exception to the rule.

In clinical work with clients affected by cancer the issue of time is very much present. It is not only the client's potentially limited life expectancy but also therapy can be of limited time. The existential approach places great attention to the issue of time in relation to the finite nature of existence.

'I: So how does the existential approach come into your practise?
R: Particularly, I suppose, awareness of time limits'
C.

In addition to the client's possible limited time, the therapeutic process is a time-limited experience. Especially when working short-term; most likely within NHS services; exploration and acknowledgement of time limits is inevitable. Realisation of time limits can place great pressure on therapists.

'And actually, having short-term work for people facing that made you confront those issues because there was the sense that you had to establish the working alliance incredibly quickly. To a certain extent you had to be task focused'
C.

When therapy aims at exploring and working with the issues arising following a cancer diagnosis or treatment, a secure therapeutic relationship is necessary as mentioned previously. With time pressing when only twelve sessions are offered, establishment of the therapeutic alliance needs to be achieved early on in the work. In addition, goals need to be clarified and work might need to be more task-focused.

3.2 Working with existential issues and death being present in the counselling

room

Working with clients affected by cancer means working with '*big issues*'; existential concerns. Participant E views such practice as an opportunity, emphasising and repeating the word '*chance*' possibly meaning '*opportunity*', to express and explore these concerns which as she claims give meaning to her work.

'I think there's a chance to talk about - chance I think actually(...) there's a chance to talk about real life concerns and things that kind of really have an impact for people and big changes, big concerns, big issues'
E.

Existential issues, feelings of isolation, limitations of time and realisation of one's mortality, reviewing life and relationships and of course death are being present in the therapy room. For participant B this context gives her the opportunity to work with experiences and issues that are not the everyday. This rises the challenge and interest in this kind of clinical practice.

'Working in this context because you see things and hear things and you're with people for experiences that are not the everyday'
B.

Temporality is at the core of human existence and death the ultimate limitation. '*The elephant in the room*' represents the presence of death in the therapy room. Even though at times, it was not talked about explicitly, participants admitted feeling its presence. Temporality as it will be illustrated below refers to two elements: On the one hand the

client's limited life expectancy and on the other its representation in the therapeutic process.

'You don't have time and also it's to do with the enormity of death and the seriousness of the illness'

F.

A cancer diagnosis as mentioned earlier unavoidably awakens the possibility of death. Participants' experiences to the presence of death in the therapy room were explored and presented below.

'So for me it was very... there was this elephant in the room of you know death... the presence of death that I really felt...'

A.

Participant A describes death as '*an elephant in the room*' something that has a very large presence. This is a commonly used phrase that aims to describe the sense of not acknowledging the obvious, underpinned by an unspoken agreement to mutually avoid painful issues. Although the origins of the phrase are unknown, its wide use as a proverb shows it taps into something widely familiar and also shows how concepts are socially constructed.

'The element of death is always present but with her it was so obvious'

A.

That '*elephant*' had a significant meaning to the participant's way of being with the client. The participant has chosen not to explore in greater depth the possibility of the

client's death. That choice either meant her respect to the client not being ready or her own hesitation to enter such a challenging area. Thinking of her existential background the participant then reflects upon her practice and way of being and acknowledges that possibly the client could have lived more in the here and now if more attention was paid to this issue.

'I never really pushed her on that [exploring her death] and pushing is the wrong word but I wonder if by facing up to it much more clearly she would have lived in the here and now more intensively'

A.

Even though the participant chose not to '*touch the elephant*' she realises it does not go away and acknowledging it causes her feeling uncomfortable.

'I: You said before that even if you didn't openly talk about it, the elephant was always there...

R: Yes

I: ...the possibility of dying

R: Yes

I: ...how was that for you having that elephant in the room?

R: It was difficult for me it was difficult'

A.

From the participant's experience it is obvious that often therapists have to work with the client's denial. Even though participants believed that exploring, acknowledging and coming to terms with their potential death would help clients, they accepted their denial or choice not to look at that possibility.

'I suppose the thing about it is the threat of death and the inability to talk about death. Because a lot of the work is with people who not only...well

they're denying death to the point that they refuse to speak about it. You know, it's the thing that is sort of like unspoken in a room'
B.

As discussed previously therapists working in this context will have to deal with the presence of death and the client's response to it. There is no denying that such a presence impacts upon the practitioner too. As participant C claims:

'there's the loss of health isn't there. You have to deal with that. But I think for me the difference [between clients with cancer and healthy clients] is, they've got... there's the possibility of them dying. (...) It's more realistic.

I: How did it affect you to have a client who is potentially dying...?

R: Well it's upsetting actually. It is upsetting.

C.

For participant C the client's illness gives a different quality to the psychotherapeutic work. The possibility of dying upsets the therapist and forces her to accept the client's reality. The participant adds that the client's condition forces the realisation that there is a limit to life.

'But you've got to learn to sort of live with that fact that you have to say goodbye to all your clients at some stage. And I sort of accept that a lot more now than working with a client who suffers from cancer. That's more final, if they die. You sort of look at your life differently when you know there may possibly be a limit to it, your perspective changes'

C.

Looking at the participants' responses to clients' condition there was acknowledgement of what the condition meant to the client and while showing respect therapists explored and worked with it. Participant E does not assume that clients would be willing to

explore their condition, rather gives them the freedom not to talk about it. She finds herself obliged to respect the client's individual decisions and accept her wishes.

'Because you kind of think that because they're close to death and they want to talk about it so they should shouldn't they because they're close to death and they should be doing this. But actually they don't want to talk about it and they want to do crosswords, and you just accept that that's what they want to do and they don't want to speak to their parents and they don't want to resolve those issues and I need to respect that. There's some level of acceptance of that'

E.

A slightly different experience is presented by participant F who felt being in 'bad faith' in Sartre's words if he did not encourage his client to face up to his death.

'One of my things was to try and find a way of speaking about it with people, to...my view was that it would help them somehow to acknowledge the possibility at least of their own death. it kind of felt that if I was with somebody who clearly wasn't going to survive much longer, for me to act as if they were was absolute bad faith, the ultimate sort of bad faith really. And so I've worked with them...yeah, and even the mention of cancer for a lot of people was difficult.'

F.

However, the therapist acknowledges how difficult this condition is for the clients.

Another existential issue that participant F was faced with was dealing with the client's feeling of isolation.

'So to have somebody go in there and just sit quietly with them sometimes and slowly, slowly allow stuff to emerge. I mean, you need the patience of a fisherman really I think to do this work, it does require a lot of patience and no real expectation and a willingness to engage with this person'

F.

The participant experienced relatives and nurses moving away from the dying person therefore he felt it was him left to engage with the ill client. From his words the participant shows how much he values the therapeutic relationship and the fact that the therapist is someone who has to stay close to the client when everyone else moves away. He emphasises the patience and courage needed for this work as well as the great will and motivation required by practitioners.

3.3 Working with the physical dimension

A cancer diagnosis can affect all four dimensions of the individual's existence: primarily the physical, the social, the personal and the spiritual. Existential therapists in the process of the clinical work usually aim at addressing all those dimensions.

The physical dimension is obviously the one affected first when a cancer diagnosis occurs. This subtheme is exploring how physicality appeared in the psychotherapeutic practice and the meaning it had for the practitioners. Therapists working with ill clients would have to be faced with the physical deterioration of their clients at some point in therapy.

'I think when she first presented of course she had completely lost her hair she was wearing a scarf around her head she was clearly, chemotherapy had clearly drained her she was weak and didn't look well'.

A.

Participant A described her difficulty in facing the physical deterioration of her client. Death becomes visible when the client deteriorates affecting the therapist too. The therapist is required to work with what the participant B describes as the '*physicality of dying*'.

'His physical well appearance apart from his face is disintegrating really. (...) and to see that visually is very, is quite disturbing. And it's a very bodily experience and I think that's also what people perhaps forget (...) the viscosity, the physicality of dying'

B.

Unpacking her experience, the participant describes her difficulty when the client's bodily boundaries begin to fail. Again the participant uses the word '*disturbing*' to describe her experience meaning she is also disturbed by facing the client's death. She stresses how cancer impacts upon our bodily functions causing them to break down and changing the individual's essence. She also explores the meaning all those changes have for the individual. For her physical deterioration is an additional dimension to dying.

'the body's sort of gradually falling away and deteriorating or just cancer patients sometimes the whole kind of breakdown of the body boundaries. And this is something that's very difficult for us because we live very boundaried in our bodies we like to be in control of our bodily functions and that whole experience is another whole dimension to sort of end of life experience and with the bodily experience and how one is with that (...)' To see that sort of deterioration can be very disturbing'
B.

Furthermore, the participant shares her struggle to accept the physical deterioration of a client who is close to death. Even though the client might have come to terms with his death, the therapist needs to accept too.

'And now it's he accepts that he's moving closer and closer to it and it's me who sits there thinking "How can this be? Look at him, how much worse he is today." That's – and it's terrible to see'
B.

Participant E approaches the client's physical condition as a given in their life. Physical pain causes anxiety and fear for the client but possibly for the therapist working with her as well. She also explores what all those changes mean to the client following a phenomenological way of working. She uses '*you*' possibly referring to the client but

possibly including herself. She recognises a '*different quality to the work*' in exploring how it is to live, while dying.

'it's in any way that we can help to ameliorate what can be a very painful thing to face that you've got a disease that – and that the fear and the anxiety of the physical pain so when the two are always entwined and how you deal with that disease spreading in your body and what all that means to you. And how you approach your own sort of dying really and how you continue to live with that and still be in living which is another whole aspect there's a different quality to the work'
E.

Participant F refers to the physical dimension in therapy from the therapist's point of view. In particular, he described how he experiences the client in his body. He listens through not only his ears but through his body as well as gaining a '*whole body experience*'. This shows the importance the client's '*words*' have for him that he attends to the client with his whole being.

'I've also become much more aware of the unspoken and the non-verbal dimension in therapy and what is happening to me in a physical way that I wouldn't have particularly taken notice of years ago. I've become much, much more focused on listening to my own body. That's the best way I can put it really, listening to my own body. But what I would say, put it this way, that listening to the client becomes a whole body experience rather than something that is concerning my ears and that I also believe that what is said and not said by the client is a response to the quality of listening rather than the other way round.'
F.

Listening with his whole body is very important for participant F as he believes the quality of his listening impacts upon the client's comfort and openness.

3.4 Therapist's preparedness and vigilance

This final sub-theme captures the essence of the participants' reflections upon this kind of clinical practice in relation to '*preparedness*' and '*vigilance*'.

While participants reflected upon their experiences several issues that therapists need to work on prior to begin working with clients diagnosed with cancer were identified. Existential therapists are prone to choosing to work with clients diagnosed with cancer as many of the issues arising for clients are existential in nature.

Participant C suggested it would be useful for therapists to have some knowledge of cancer itself. Cancer is a complicated disease as there are several types, stages, treatments and side effects. Basic knowledge can be helpful in understanding the client's health condition and psychological state.

'Everyone who's trained as a therapist, could have an awareness of some of the issues around cancer. Especially in how much it links into all the existential issues'
C.

Many therapists refrain from working with clients close to death or even of ill health. People often find this kind of work upsetting and often fear being '*contaminated*' or raising the possibilities of becoming ill themselves. Participant C claimed that trainees could learn from the exploration of therapists' experience who have worked in this context. She also proposes an effort to overcome the fear and offer our services to people in need.

‘But maybe if it was addressed, touched on more in the training so that people wouldn’t be afraid of it because I don’t think you have to have specialist training’
C.

Subsequently, therapists who wish to work with clients affected by cancer should have explored several issues within themselves first. Therapists should dedicate some time exploring their relationship to their mortality and ill health before trying to enter the client’s world. Willpower, a genuine interest, curiosity and of course empathy and humanity are necessary qualities in order to get involved in such a working environment.

‘That’s the art of empathy, isn’t it; we’re trying to understand what it’s like inside our clients’
C.

Existential therapists should be ready to enter and explore ‘Being’ -with a capital B- something most therapeutic approaches abstain from. The limited time adds another pressing dimension to this kind of clinical practice. Therapists need to encourage clients to feel comfortable sharing their deepest fears in a short period of time which means they should simultaneously feel comfortable themselves in doing so.

‘the person needed to be given the opportunity to talk about these things with somebody who was comfortable in so doing, quite early on.’
C.

One task of therapy when working with terminally ill clients is helping them come to terms with their potential death. However, when clients manage to accept their death it is the therapist’s turn to accept and let go of his/her client. As motioned previously, the

therapeutic relationship is a very strong bond and therapists are inevitably affected by their clients' condition. From participants' experiences it was evident that occasionally even when the client is ready to go, the therapist needs time to accept too.

'coming to terms in some way which he has. And I would say it's more me now that's the one that's sort of sitting there'

I: So is it a question of actually the therapist coming to terms with the fact that their client is probably dying?

R: Absolutely yes, yes'

B.

Assisting clients into coming to terms with their death can be frightening for the therapist too. Participant F recognises his strength, courage and determination in not being frightened by the client's fear. This illustrates the '*preparedness*' necessary for working with clients near death.

'And I think that's one of the things I'm quite good at doing is allowing people to feel their terror, to work with that, because I suppose one of the messages I give somehow is that I can hold it, that I'm not frightened of their fear'

F.

Subsequently, participant F illustrates that '*preparedness*' also involves recognition of one's '*taboos*' in relation to death, cancer as well as personal taboos. He illustrates that the therapist should be prepared to look at '*the little frightened person*' hidden at the core of somebody.

'But when you come across like the young man who I was with just before he died (...) it's almost like you enter into it with something you really don't know about and yet you're bringing with it a lot of your own taboos. You

know, that word is quite a good one actually for...you know, there is a...there are many taboos that you have to sort of work your way through.

Yeah, there's the taboo of death, there's the taboo of cancer, but also there's that sort of personal taboo of allowing somebody to see that person that is right in there, that really frightened little person that is right in the middle, you know, at the core of somebody. Or a very British thing, you know, to allow someone to see that you're terrified. You know, to put on a stiff upper lip'
F.

Exploring his experience further, the participant was asked to reflect upon his fears. The participant highlights that it is very important for the therapist to be able to acknowledge and allow, give permission to himself/herself to experience fear first in order to be able to do the same for his/her clients.

I: Do you think it's quite an important aspect that you allow it to yourself, you allow the space to be afraid or to think about your own death and your own mortality?

R: Yeah. I think, yeah, I think unless you do it you can't do it for them, yeah.

I: So in a way it gives you the strength to be able to sit with somebody else's fear.

R: Yes, but it's rather than just...it's not so much about entering into your own fear, but giving yourself permission to acknowledge that you have the fear'

F.

The therapist can offer a unique experience when being prepared to listen and be with to the client's most painful experiences and fears. Not many people are prepared to offer such an experience and it is very common for relatives to avoid having such difficult conversations.

‘they really often seem to appreciate having someone who is prepared to talk about what they can't talk about with them [relatives]’
F.

In addition to preparedness, vigilance is also expected by therapists. Particular attention is required by therapists in taking care of themselves especially when working in such contexts. When work with clients with cancer is the main area of practice, as participant C claims, the therapist can experience emotional burnout, feel detached from her clients and their condition. Practice then becomes automated; lacking empathy for what the client is going through resembling cancer doctors’ way of being around their patients. She proposes that working in other contexts too is very important in order to avoid becoming ‘immunized’.

‘if all your clients have cancer, I’m thinking, oh here’s another one and being so familiar that you lose touch with the immensity of that for someone when it’s actually the first time in their life. Because you’re dealing with it all the time, which must be what cancer doctors are like. So you can become immune to it in a way so it was good to only do it a small part of the week’

C.

‘Vigilance’ also refers to recognising the need to take time off practicing. Personal cancer related experiences or even the therapist having cancer himself could require a time off practicing. Prevalence of cancer these days has increased and. therapists are not excluded from the danger of being diagnosed at some stage in their lives. Reflection is paramount in those circumstances in regards to taking time off.

‘(...) how much people should go on working while they’re going through cancer treatment themselves, for example, I think, is a really difficult thing to manage, especially in private practice. I think if someone’s income is

*dependent on it and how you do that, how you disclose or not to clients.
And when [relative] had cancer again, I took some time off work'*
C.

The participant raises several ethical issues and dilemmas in relation to clinical practice. Often taking time off work is not possible when one's income depends on their practice. In addition, disclosure is another challenging issue for the therapist raising several questions such as: why? Who is it for? And how much is appropriate? Speaking of her personal experience the participant was able to act responsibly and take time off work however, she claims this is not always the case with other colleagues. It is very important for therapists to have enough support systems in place and know how to take care of themselves.

'So I do think it's really important that I or the counsellor can show that they've got enough support systems in place for themselves and they can take care of themselves. But on the other hand, there's also... if you have been touched by cancer in your own personal life, even if it's an aunt or a friend from years ago, actually you're closer to having experienced what comes up'
C.

In the last quote participant C illustrates the importance of self-care.

'Sometimes I work less in it because I've deliberately drawn back at times'
C.

Without taking care of themselves therapists will not be able to help their clients effectively. The participant chose to work less with clients with cancer recognising the emotional impact and demand this work had upon her.

Discussion

As Smith et al. (2009, p. 112) suggests in the results section of a research project '*the interpretative account provided is a close reading of what the participants have said*'. Here the results are being placed in a wider context. Smith continues that '*it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory*' (Smith et al. 2009, p. 113). It is understood that this research is only one construction of the phenomenon of offering existential therapy to clients with cancer and includes parts of the researcher's interpretations.

Reviewing the research question

Having explored the study's findings they will now be considered within the context of existing literature and relevant theoretical constructs. The results' relevance to current psychological practice will also be highlighted. It is understood that the discussion of the findings is only one possible explanation. Themes emerging from the data analysis were not always anticipated by the interview schedule. In addition, strengths and limitations in terms of methodology and conduction will be considered. Finally, contributions for future research will be explored.

In order to get an understanding of existential therapists' experience it was important to explore what existential therapy and practice means to each participant. As literature suggests, each therapist defines, conceptualises and practices in a unique way. Following a thematic analysis, a common ground was evident between practitioners. At the same time different shades coloured each individual's way of being and working with a client. It was also emphasized that the theoretical orientation alone does not make a therapist. The therapist is an individual with his/her own life experiences and meaning-making of those, which colours the way he/she practices.

It was very interesting to notice that almost all participants used a pluralistic approach in their clinical practice whilst holding the existential paradigm on the background. In brief, for some therapists the experience of working existentially was associated with practicing phenomenology whereas for others, therapy was about the relationship. This shows the flexibility of the existential approach to which all participants identified and related.

From an existential-phenomenological way of working, therapists did not focus on the clients' illness but approached them openly, exploring their lives holistically and reviewing how it was affected by cancer. As Wilkes & Milton (2006) study has shown the existential therapist holds qualities like openness, honesty and trustworthiness and values the therapeutic relationship. In addition, they noted that therapists' responses varied in relation to their understanding of the notion of techniques. By its very

philosophical nature, the existential approach does not follow any particular set of techniques. Therapists seem to approach this view in a variety of ways (Wilkes & Milton, 2006). Combining elements of Cognitive Behavioural Therapy or the phenomenological method to existential therapy offers an experience of technique usage for some participants in this study. Everything the therapist does or says or the way they are being in a session or the use of the therapist's self was also experienced by participants as *'technique'*. In this case, technique was something the therapist felt comfortable with. However, participants also stated that technique is something that *'closes down the therapist's openness'* (Wilkes & Milton, 2006, p.12). It can be concluded that there are also several understandings of the existence of psychotherapeutic techniques in relation to their use, value and impact upon the therapist.

All the above has provided valuable insight as to what existential therapy is and is not. This has been a thought provoking process and an opportunity for reflection upon my way of working and what I consider important in my practice. I have always struggled to answer myself the question of what existential therapy is. I find myself in agreement with the majority of participants' responses. As a practitioner I consider the uniqueness of the existential approach to lie in the absence of a particular structure that all therapists should follow with all clients and at all occasions. This way of approaching therapy highlights the client's as well as the therapist's individuality and allows for a personal identity of the practitioner to be developed. My understanding of the existential approach to psychotherapy is one that is grounded within philosophical ideas but most importantly it is one that respects individuality, relatedness and the human givens of

existence and dares to work with all the above. Similar to what participants discussed I have also found myself in the tension of wanting or feeling the need to ‘do’ something in my clinical work. I strongly believe that holding that tension and valuing ‘being’ with the client gives greater meaning to my clinical work. Therefore, I would only ‘give in’ to techniques when I really feel it is best for my client.

Furthermore, as the findings have indicated, facilitating exploration and description rather than interpretation is another important aspect of the existential-phenomenological therapy. More explicitly, participants facilitated the clients’ awareness, recognition of the choices they have to make in life and the fact that they are the only ones responsible for their lives whilst recognising the existential givens and limitations of life each client is faced with. Awareness of one’s choices in life is a possible aim of therapy. Clients are encouraged to live life more deliberately whilst acknowledging the fact that there are always choices available that have to be made and therapy can help in making those choices. In existential/phenomenological therapy owning one’s life and attempting to live life as fully as possible can be the goal of therapy.

From the analysis of the interviews it became evident that participants used the phenomenological method in their practice. In order to get a better understanding of this concept a brief description of the theoretical underpinnings of the phenomenological method will be provided. Spinelli (2005, p. 19) writes that the principal task of phenomenology as Husserl suggested is *‘to find the means to strip away, as far as possible, the plethora of interpretational layers added to the unknown stimuli to our*

experience in order to arrive at a more adequate, if still approximate and incomplete, knowledge of 'the things themselves'. In addition, Spinelli (2005, p.19) presents his account of the phenomenological method in three '*distinguishable though interrelated steps*': *the rule of epoché, the rule of description and the rule of horizontalization*'. The first refers to our biases, prejudices, assumptions and expectations and suggests people and therapists should set them aside; '*bracket*' them as much as possible. Consequently, an open attitude to the immediate experience is suggested. The phenomenological method does not aim at explaining but instead at describing. Therapists using this method would try to make sense of their clients' experiences without making any interpretations in the sense used for example in psychoanalysis. Lastly, the rule of horizontalization opposes from placing hierarchies of importance or significance and instead suggests treating everything as having equal importance and value.

There are several questions arising whilst attempting to provide a definition of the existential approach to therapy. One involves phenomenology and the phenomenological method. Are therefore all existential therapists phenomenologists? Is the phenomenological method at the heart of existential practice? According to the findings of this study it seems that phenomenological method is used in practice by some but not all practitioners who claim to be existentialists.

Yalom (1980) provides us with a very useful and apprehensible definition of four existential concerns: the inevitability of death, freedom and the subsequent responsibility, isolation and meaninglessness. Being human includes tensions within all the above issues that can be addressed by therapists from different orientations. So

another question arises of whether all therapists who claim to address the above issues in their practice, are in fact existential therapists?

Spinelli (2007, p. 16) talks about *relatedness* or *inter-relation* being at the core of existential therapy. The only way we can understand ourselves, others and the world is through the inter-relational context. This idea has important implications for the existential practitioner whose focus is not the client in isolation but rather the way that *relatedness* appears through the client's narratives of his experience of being and also through the lived experience of relatedness in the therapeutic space. In addition to *relatedness*, *uncertainty* and *existential anxiety* are necessary ingredients in an attempt to answer the question '*what is existential therapy?*' (Spinelli, 2007, p.30). From the themes that emerged from this study it was noted that all the above appeared in the participants' experiences.

Therapeutic approaches that focus on meaning-making such as Frankl's logotherapy (1950; 1988) can be another form of existential therapy. However, meaning and meaninglessness is a foundational idea in existential philosophy and practice.

In my personal view, it seems that similarly to all therapeutic approaches, existential therapy is becoming an umbrella-term containing all the above and maybe more. In my clinical practice, I tend to explicitly share the responsibility of the therapeutic process with the client thus clarifying he/she has the choice of how to use his/her time, what he/she wants to disclose and what not and inform me if something is not useful or working for him/her. I strongly believe this is an important moment in therapy as

sharing the responsibility creates a sense of sameness between us in terms of power dynamics. In addition, I believe giving agency to the client can offer them a sense of control in their lives and taking responsibility of therapy is a good starting point for ownership of life in general. Consequently, this study offered a description of the six views of participants rather than a conclusion and a clear definition of what existential therapy is.

Emotional impact of the work upon the therapist

Smith-Pickard (2010) described the experience of working with clients with a short prognosis in a beautiful realistic sentence claiming that *'the work is not easy and we pay an emotional price for doing it'* (Smith-Pickard, 2010, p.139). It was very interesting to notice a paradox in participants' experiences. Even though therapists pay an emotional price, they also gain gratification, satisfaction and knowledge. As van Deurzen (2009, p. 21) writes *'experiences come in opposites and we need to wonder where the opposite polarity is hidden'*. Recognising the two polarities helps in getting a better understanding of the experience. Participant F points out the fact that therapists tend to fear working with cancer. He expresses a wish also shared in this study that fear could be eliminated and a better understanding of cancer and death can occur.

'Possibly eliminate the fear people have and therapists to work with cancer. It's as hidden as death itself, I think, cancer'

F.

The emotional impact of working with clients affected by cancer was greater than expected. Participants were touched on several levels either by being reminded of their personal experiences and losses or realising their finite nature or even experience the loss and sadness following the death of a client. It was highlighted that working with clients diagnosed with cancer can be challenging but becomes even harder when unresolved feelings and personal experience are awakened for the therapist. Participants expressed a variety of emotional responses. Those included feelings of anxiety and uncertainty in relation to the client's future, feelings of loss and sadness when they didn't have the time to say goodbye to their clients, intensity and feelings of urgency in relation to the client's limited future as well as the temporal nature of the therapeutic encounter.

From participants' accounts it becomes evident that they have been deeply affected by their clients. Feeling brutalised, feeling the client's anxiety, struggling with uncertainty and having to stay with not knowing. Not knowing what will happen to the client, what happened to the client when therapy was over and also mourning for the loss of a client. Even though cancer is not always fatal, death seems to be a common event in treatment units. Unlike sudden unexpected losses, death by cancer can be a slow process, that although allows time for acceptance, it still comes as a shock and has a significant impact upon the practitioner (Baum and Andersen, 2001).

Therapists also claimed feeling out of depth at times. A feeling of *vertigo* when facing something much more powerful than expected. Parkinson (2003, p.424) also describes in a powerful way her similar experience.

'I ... felt shocked by her pale, gaunt appearance and aware of a sudden draining away of my own feeling of confidence and competence as a professional'.

She also emphasises the impact of the deteriorating physical appearance which is something that could have been further explored in this study. A few participants elaborated upon the impact of the client's physical deterioration upon them claiming it was a very difficult experience as the physicality of the illness had a very strong impact and left no room for denying the illness's presence.

Parkinson (2003) offers an additional element to this kind of work, the therapist's realisation of his health and well-being in comparison to the client's ill health. She suggests that the therapist might find herself idealising the ill client for his struggle and courageous efforts to cope. In addition, she refers to unconscious states of mind that can be transferred from the client to the therapist. She uses two examples in order to illustrate this:

'The first is of a crippling and very frightening feeling of claustrophobia I experienced immediately before I saw a new patient, who told me in the first few minutes of the session about how badly trapped he was feeling by his illness. This man was in an acute state of anxiety which, at that moment, was made all the worse by his anticipation of an X-ray procedure he was due to have that day, which involved being temporarily physically 'trapped' by the X-ray apparatus and unable to move, as he was required to keep still in order that the machine could take photos of his body' (Parkinson, 2003, p. 423).

Participants also emphasised the relational element of their work, the encounter with the client. Therapy is not only learning about the client rather as May (1983) states *'the grasping of the being of the other person occurs on a different level from our knowledge*

of specific things about him' (May, 1983, p. 92). One of the main aims of psychotherapy is consequently to be able to understand and meet the client in that sense through the encounter. Barraclough (1999) indicates that regardless of the therapeutic approach employed, it is the establishment of a trusting therapeutic relationship as well as the patient's motivation that are very important when treating clients with cancer.

Whilst therapists attempt to assist clients in creating new meaning in their lives following a life changing event and while going through difficult and painful treatments, they also worry about whether they will survive. As participant B claimed this is the therapist's predicament. van Deurzen's (1997, p.5) statement seems to apply to both therapist and client.

'Embarking on our existential journey requires us to be touched and shaken by what we find on the way and to not be afraid to discover our own limitations and weaknesses, uncertainties and doubts. It is only with such an attitude of openness and wonder that we can encounter the impenetrable everyday mysteries, which take us beyond our own preoccupations and sorrows and which by confronting us with death, make us discover life' (van Deurzen-Smith, 1997, p. 5).

In this kind of therapeutic work, client and therapist should be open to recognising and accepting their limitations and weaknesses; staying with their uncertainty and embracing the unknown. Through confronting death and fear humans can fully discover life and living.

A paradox arose in the third subtheme. Participants' experienced a very close relationship to their clients described as *'unique'*, *'love'*, *'as close as it gets'*.

Speck (1994, p.100) contemplates the idea of an '*unconscious attraction*' to work with dying people as it can serve the fantasy that death only happens to others and not ourselves. This could be explained by exploring the cancer related experiences of the practitioners as a possible explanation of their choice to work with clients diagnosed with cancer.

An interesting parallel process was noticed between the clients' experiences of cancer as presented in the literature and the therapists' experiences as explored within this study. Clients diagnosed with cancer struggle with a range of feelings such as depression, anxiety and fear. Similar feelings seem to arise for the practitioners too, as it has been indicated in this study. However, for both therapists and clients, experiences can entail positive feelings and creation of meaning (van der Lee et al, 2006). For the client it can be an opportunity to become more engaged in life and for the therapist, as it emerged from this study, can be a very rewarding work but also impact significantly upon personal levels.

The numerous implications and additional dimensions that need to be considered in this kind of psychotherapeutic practice were explored in terms of practicalities but also in terms of the therapist's personal involvement. Participants were in line with Straker's (1998) claim that flexibility is paramount in this kind of clinical practice for both therapist and client. Because of the nature of the illness, the unexpected changes in the client's condition and the side effects of treatment lead to psychotherapeutic work to be regularly interrupted or forced to follow the medical needs of the client. Often sessions can take place in busy hospitals, might be interrupted by medical staff and rescheduled due to treatment arrangements. It is also important for the therapist to have some knowledge of the illness and what is involved in the treatment process in order to be able to appreciate the client's difficulties and the need for flexibility. Consequently, boundaries are being challenged. The client as well as the therapist could find themselves feeling '*out of control*' it is therefore important for both to explore what that means (Parkinson, 2003).

Smith-Pickard (2010) claims that any efforts the therapist makes to create a safe and secure space for the client can be destroyed in seconds by a doctor, nurse or relative storming in the room. The experiences of participants in this study illustrated a similar environment that is very different from what therapists are used to. This is a significant characteristic of this kind of practice that could be proven useful for newly qualified practitioners wishing to work in similar contexts.

Straker (1998) writes that following a cancer diagnosis feelings of anxiety, depression, despair, hopelessness and meaninglessness can arise. Existential therapy aims at addressing those issues which in addition to existential therapists' eagerness to work with them possibly makes existential therapy a more suitable therapeutic approach. Furthermore, effective cancer counselling could be based on the four existential concerns: death, isolation, freedom and meaninglessness (Yalom, 1998). As it was illustrated from participants' responses those existential concerns were often part of the therapeutic process. However, it is not uncommon for clients to talk about other issues such as traumatic events, regrets and wrongdoings and issues unrelated to cancer.

The final sub-theme of the third super-ordinate theme was thought to provide guidance to anyone wishing to work with clients affected by cancer and an opportunity for reflection for practitioners already working in the field. More specifically, practitioners should be willing and prepared to explore their relationship to the existential concerns and death in particular, and identify their '*taboos*' in relation to those issues as participant F states.

Clinical supervision and the therapist's self-care should also be considered. According to Straker (1998) recognising and monitoring the therapist's '*countertransference responses*' is achieved through supervision as well as case peer discussion groups.

Working with existential concerns, involves the need for the practitioner to have previously explored them within himself/herself in order to be prepared to listen '*without taking flight into cliché or unrealistic hopefulness*' (Lockett, 2010, p.46). In

order to be able to create an open, safe and emotional space for exploration the therapist needs to have done the same for himself within himself. Reactions to the emotional impact of the client are inevitable and often therapists as well as other medical staff, for example nurses and doctors, tend to distance themselves by choosing neutral topics of conversation, ignoring the patient's emotional comments and attempting to make the patient more cheerful (Parkinson, 2003). Speck (1994, p.100) implies a '*chronic niceness*'; an attitude adopted by carers, therapists and medical staff aiming to be protected from the primitive and powerful feelings that arise from this encounter.

Lastly, it was important to acknowledge participant F's contribution who introduced an additional dimension; that of being unwanted as a therapist by the client and struggling to engage with the client who resists. For Smith-Pickard (2010) this adds to the difficulty of the work and occasionally it is one of the first difficulties the practitioner wishing to work in such settings will encounter.

Reflections on the analysis and outcomes of the study

In the previous chapters, reflections have been provided in terms of my personal involvement in the design and conduction of this study including the process of interviewing participants. Having discussed the emergent themes from a theoretical perspective, a reflection on the process of the analysis will follow considering my involvement in the development of the themes. An attempt is therefore made below to reflect upon how I have '*shaped the research process and finding*' (Willig, 2001, p.10).

As stated previously in this study, there were several personal reasons prompting me to conduct this research project. It is my interest in psychotherapeutic work with clients suffering from life threatening illnesses as well as my efforts to balance my feelings attached to this kind of clinical work that developed into this research project.

During the process of analysis my aim was to be as open as possible, recognising my preconceived ideas and knowledge whilst attempting to capture the participants' experiences. An attempt has been made throughout this research to keep those influences in mind and recognise them as they emerged either during the designing, interview, analysis and write up stages. I was careful not to end up with outcomes that would become a '*self-fulfilling prophecy*' by paying attention to my anticipations and expectations, getting the answers I expected to get or wanted to get and recognising unanticipated outcomes (Glesne & Peshkin, 1992).

In the final stages of the analysis and after having extracted themes from all six interviews, it was not easy to come up with cross themes. Participants' experiences seemed all very unique and significant. There was a feeling that most of them could have been used as single case studies as they offered very interesting and rich material that could have been further explored on a much more personal level and in greater depth.

As cross themes emerged, there was an effort to capture the common themes but without missing out participants' individual experiences and uniqueness. All the way through analysis I was concerned in terms of the idiographic nature of IPA. Attention was paid in refraining from being more descriptive than interpretative and it is believed that this task has been achieved. Any interpretations were therefore carefully made with reference to Smith's (2009) suggestions.

Analysis of qualitative data is a lengthy and time consuming process. I was once more confronted by the paradox of being engaged to the study, feeling excited about the process of developing themes but at the same time I often found myself tired, drained and disengaged. Similar feelings deluged me during the write up stage but overall conducting this study has been a rich and rewarding process.

Reflexive evaluation of the study

Methodological limitations

IPA (Smith, et al. 2009; 1999) was considered as the most appropriate method for illuminating the lived experience of offering existential therapy to clients affected by cancer. Supplementary, the thematic analysis that was conducted offered a sound understanding of the way practitioners conceptualised the existential approach emphasising its unique characteristics comparing to other psychotherapeutic approaches but also highlighting the individual understandings and different ways of applying it to clinical practice.

Conducting thematic analysis as a method of analysing qualitative data obtained from this particular question and complementary to IPA, was initially approached with scepticism and created feelings of uneasiness and hesitation as to whether it was appropriate to use both methods of analysis. Looking at the study now, I feel this was an appropriate action as the study better portrays the therapists' view of the existential approach. In this first question of this study the focus laid on *what* the participants shared and not on the *how*. The researcher's interpretation was not relevant as a descriptive presentation was required in order to better capture participants' understanding and way of practicing. Thus, it is believed that the study represents a good example of when IPA should be used, that thematic analysis is indeed a very useful method of analysis and also highlights the different approach to the researcher's involvement. Binswanger (1956, p. 200) highlights the double advantage of an

existential –analytical research *‘it does not have to deal with so vague a ‘concept’ as that of life, but with the widely and completely uncovered structure of existence as ‘being-in-the-world’ and ‘beyond-the-world’.* In addition, *‘it can let existence actually speak up about itself –let it have its say’* emphasising the importance of language as phenomena are actually language phenomena.

Another possible limitation of this study lies in the sampling selection. IPA sampling tends to be purposive and broadly homogenous as a small sample size can provide a sufficient perspective given adequate contextualisation (Smith & Osborn, 2003). The initial goal was therefore was to recruit exclusively psychotherapists of an existential/phenomenological background. However, two participants identified themselves as integrative in their theoretical training and clinical practice. Furthermore, participants differed in their clinical experience in relation to working with clients affected by cancer. It could therefore be argued that therapists from the same theoretical background and with the same level of relevant clinical experience might have provided different finding. However, it should be noted that other authors have argued for the use of heterogeneous samples when using IPA, as it allows generalizability of findings and captures diversity of perspectives (Carradice, Shankland & Beail, 2002). Furthermore, the purpose of the present study was to carefully examine and illuminate therapists’ experiences of working with cancer clients regardless of the level of clinical experience in this particular field of clinical practice.

Qualitative research also acknowledges that there are biases that the researcher brings to the research process. In IPA, the researcher’s perspective will inevitably have an effect

on the interpretative process (Smith 1996), which can raise questions of reliability and validity (Golsworthy & Coyle, 2001). An effort was made during the whole process of this study, interviews, readings, analysis and interpretations, to ‘*bracket*’ any assumptions, remain aware of my own thoughts, feelings and potential biases in relation to this experience. In order for this to be achieved thoughts and feelings were noted and explored in order to be managed effectively, supervision was attended and a peer group offered guidance and support.

Despite attempts to acknowledge and ‘*bracket*’ existing knowledge and preconceptions, it should be noted that the researcher’s professional identity as an existential therapist and personal experience of losing a close relative from cancer, as well as influences from previous literature findings might have constituted a bias in the interpretation of the data. An attempt to safeguard validity of the research project was made by conducting an initial pilot study, as well as by cross-validating the interpretation of data with four other counselling psychologists. As Reason (cited in Maxwell, 1996, p. 12) argues critical subjectivity, is ‘*a quality of awareness in which we do not suppress our primary experience; nor do we allow ourselves to be swept away and overwhelmed by it; rather we raise it to consciousness and use it as part of the inquiry process*’.

Finlay & Evans (2009, p. 30) suggest that a great deal of what we can learn through research is from what is happening in the ‘*intersubjective space*’ between the researcher and the participant. An attempt has been made in this study to consider this very interesting view of relational research and it has been achieved at an adequate level yet there is always more that could have been done. Staying more with the participants’

personal experiences for instance, focusing on the here-and-now and the dynamic process between us, could have possibly provided with more in depth personal information and concrete evidence of the link between cancer-related personal experience, loss and developing an interest in working in such settings. Regarding the choice to work in this particular setting it was for most participants, personal reasons and internal motives that drove them to work with clients affected by cancer and in a similar way it was what drew me to develop an interest in this kind of practice too and consequently conduct this study. In addition, reflecting upon the relational aspects of the interview process, as it was evident from the participants' accounts, it is possible that clients attempted to '*protect*' therapists by not exploring openly their fear of dying. In a similar way, I felt I was abstaining from those issues during the interview process. As a number of participants stated, they felt they could have done more with their clients. I was left with a similar feeling that there was something more I could have obtained from the interviews.

In the 1980s, Guba and Lincoln substituted reliability and validity with the parallel concept of '*trustworthiness*' that contains four aspects: credibility, transferability, dependability, and confirmability (Morse, 2002). Throughout this study an attempt was made to ensure trustworthiness and achieve confirmability. In particular, Guba's (1981) criteria were attended to:

- Credibility: An attempt was made to demonstrate the true picture of the experience under investigation.
- Transferability: Refers to applicability of the findings to another context.

- Dependability: Refers to the stability or consistency of the inquiry processes used over time.
- Confirmability: Refers to the quality of the results. Throughout this paper an attempt was made to demonstrate that findings emerge from the data collected rather than the researcher's predispositions.

In order for the above to be achieved, the study was reviewed by four chartered counselling psychologists. Their valuable feedback was carefully considered. For example, a more in-depth interpretation of the results was suggested. In particular, before arriving at their final form, themes were cross-referenced and the final analysis was cross-validated.

Occasionally, during the write up stages of this study, reflexivity became a source of frustration as it can be a never ending process. I can now see how it has informed not only this study but also myself in terms of my personal and professional development. It has helped me clarify my values, thoughts, biases and recognise that I cannot bracket them off completely but rather acknowledge them and allow them to exist.

Limitations and learning outcomes

Patton (2002, p.35) warns perspective researchers that qualitative research is '*time consuming, intimate, and intense*'. This study took place over a period of three years. This was a very long time that had positive and negative characteristics attached to it.

Adequate time was allowed to the analysis and interpretation processes to occur. Every time I re-read what I had written, a new interpretation would emerge. The same kept happening at the write up stage where new things were always coming up in terms of ideas, thoughts or reading new articles. There was always something I hadn't considered previously, something I could rephrase or even new books and journals being published that could inform my study. However, through this process I reached levels of tiredness; both physical and psychological; I had never experienced before. Considering my limited research experience this project felt and was actually taking over my life for a very long time. Juggling between feeling guilty every time I decided to focus on something else and feeling excited when a thought or new interpretation of a participant's quote occurred suddenly, my life circulated around this project.

Working with clients diagnosed with cancer is a client group I would very much like to work with in the future, as I reckon that valuable work can be achieved. I believe that clinical practice within hospitals and palliative care settings can challenge the ordinary psychotherapy norms and also challenge me on a personal level too. It can be a context of practice that causes anxiety to the practitioner but at the same time offer the opportunity to be creative, flexible and adaptive. Some of my pre-existing beliefs and

ideas were confirmed by this study. Nevertheless, there have been significant discoveries and issues arising that had not been previously considered.

Practice and experience make a practitioner and a researcher better. Should I have been more experienced in terms of conducting qualitative research, I would also be more confident in terms of interviewing and analysing qualitative data. Even though a lot of studying took place prior and during this research project it was my first attempt to conduct a qualitative study. However, the overall process was considered a great learning experience that offered knowledge through practice that will definitely be reclaimed in the future.

While this study was taking its final form, several incidents occurred in my life requiring attention, time and affecting me mentally and emotionally. My godmother who was diagnosed with cancer shortly before I decided on the topic of my research, passed away. I believe she was the reason I decided to look at cancer rather than any other terminal or chronic illness. Her death was a big loss for me. An additional, big change and loss was moving back to Greece after living for eight years in the UK. This decision had a big impact on this study's progress as my resources in Greece were significantly limited and precious time was lost in my efforts to restart my life in Greece. Through this process I became aware of the study's gradual development and also my own development as a researcher and practitioner growing with it.

Following the completion of this project I am becoming aware of the major importance of the therapeutic relationship not only for the client but for the therapist too. Sharing the

deepest fears, the fear of dying can be a unique, valuable experience for the therapist in addition to being an opportunity for the client.

As argued at the beginning of this study, I engaged to a topic that was very close to my heart, very important and meaningful but again the way I chose to relate to it was from the safe distant position of the researcher. In addition, as the write up process and completion of the project has taken several years I found myself in a similar tension of wanting to work on my project and at the same time feeling disengaged.

Upon reflection, I strongly believe I have gained a lot from the process of conducting this research project. I got to see other peoples' views and explore different experiences, I felt surprised when similarities to experiences were coming up such as having a personal encounter with cancer or different opinions for example in relation to the focus of existential therapy.

With regards to personal development, this study served as a reminder that unfortunately I work better under pressure regardless of the fact that common sense is saying the opposite. This has been possibly the most difficult journey I have travelled so far evoking questioning of my abilities, facing fears and disappointments and fighting with my hidden perfectionist self. However, I believe my aim to conduct an interesting piece of research producing findings that are tentative but could be useful in shedding some light to the mystery of therapy, was achieved.

I believe this study offers a good representation and understanding of the participants' accounts in relation to their conceptualisation and practicing of the existential approach as well as of their experience of working with clients diagnosed with cancer. The contribution of the findings to the field of counselling psychology as well as the strengths and limitations of the study will be further explored below.

Rethinking cancer

A cancer diagnosis brings humans affront with mortality. The number of people being diagnosed with cancer seems to rise over the years but so do the survival rates. Producing accurate statistics on prevalence, mortality and survival rates is not an easy process as there are numerous variables to be considered.

According to statistics the risk of death is 22% higher in Eastern Europe than central Europe, it is much higher for patients aged between 55-59 years old than for those aged between 15-54 and men have significantly higher risk of dying than women. Early diagnosis and improved treatments are possibly the two main reasons for the steadily increase in survival rates (De Angelis, Sant, Coleman et al, 2013). Even though there is a delay in the publication of data related to mortality and survival rates, it is important for all professionals involved in the area of cancer to become aware of them. It seems that early diagnosis is the most important factor contributing to the rise of survival rates and raising public awareness seems of paramount importance.

Working with clients affected by cancer means working with the whole spectrum of the illness: receiving the diagnosis, going through treatments, becoming a palliative patient or surviving the battle. The practitioner can be found working in either of those stages or through all of them. However, the issues he/she will encounter are possibly significantly different. Psychological support is also important for people who survived cancer. Research suggests that survivors face physical, psychosocial, practical, spiritual and informational challenges that could begin during treatment or even post treatment (Cowens-Alvarado, Sharpe & Pratt-Chapman, 2013).

Implications and contributions

Although, the significance of this research study has been previously presented, its implications for practitioners and the field of counselling psychology and existential therapy will be further explored below.

Relevance to Counselling Psychology

The present study is thought to provide useful insight for counselling psychologists and therapists of various therapeutic approaches. Themes that arose in this study could be possibly valid for work with other client groups such as chronic ill clients but also provide an understanding of the basics that are often overlooked; the therapists taking care of themselves and seeking personal therapy and supervision.

The first clear implication of this study is that cancer is affecting more and more people nowadays and psychology units within oncology departments are being widely established. It is not long ago that counselling psychologists found themselves working in medical settings close to nurses and medical practitioners (Hazzard & Henderson, 2004).

There is no denying the fact that therapists, regardless of their theoretical orientation, are affected by their clients' condition. Working with cancer involves additional challenges. In addition, the experience of a client's death is tough, evoking feelings of loss, sadness and in the case of a sudden death evoking feelings of shock and dealing with an abrupt

ending. Recognition of those issues could help therapists realise they are not alone when being emotionally touched by their clients nor feel inadequate when they find themselves trapped in the unknown. In both situations, therapists may be encouraged to seek support or take time off practicing when feeling the need to. In addition, this study offers an understanding of the emotional impact of the work upon therapists, the implications of this kind of practice and also looking at the possible preparation for therapists who wish to practice in a similar context.

Practitioners trained in or working from a different modality could gain useful knowledge and an understanding of the implications of the existential-phenomenological theory and practice and the way it relates to work with clients affected by cancer. Another implication of this study relates to the therapies offered within the NHS. This study highlights the relevance and appropriateness of the existential-phenomenological approach in such contexts and raises hopes for its further involvement within NHS services.

Recommendations for improved training and practice

This study also raises awareness of another very important issue, the necessity for personal therapy for trainee practitioners. As it was revealed from this study a lot of preparedness in terms of resolving unresolved issues, dealing with personal losses and developing the strength to work with existential concerns is required of therapists. In addition, therapists should have explored their feelings and relationship to death, dying and illness prior to engaging in such contexts. However, it is believed that such a personal exploration is valuable for all practitioners regardless of their theoretical orientation and context of practice. The therapist's attitudes towards death and dying will inevitably affect their ability to practice on *'what is potentially a high-stress area without becoming stressed themselves'* (Varma 1997, p. 114).

This leads to a final implication of this study which is its relation to training institutions and clinical placements. Training institutions ought to raise awareness of trainees of the emotional demands involved when practicing within hospital settings, assist in their students' personal development as well as encourage practitioners to seek roles within this field. Therapists' self-care through clinical supervision was also highlighted in the findings. Despite their expertise and experience, therapists working in such demanding posts should seek regular supervision in order to support themselves and their clients.

As a final point, despite the fact that evidence suggests psychological therapy as being beneficial, many patients diagnosed with cancer are reluctant to engage in either individual or group therapy. Barraclough (1999) claims that this possibly reflects the

belief that psychological issues are stigmatised and embarrassing or that therapy is irrelevant to their issues and possibly feel they will not be understood because of their particular condition. Patients could really benefit from psychological interventions and should be properly informed about how they could be helped and supported during their illness.

Recommendations for future research

A few issues arose through the process of conducting this study that had not been initially considered. The therapists' motivations that led them in working with clients with cancer were very interesting and could be further explored in future research. In brief, those issues were related to having personal experiences of loss from cancer and personal struggles to understand death. Additionally, the therapist's experience of the impact of the physicality of the client and the possible gradual deterioration due to illness or the loss experienced when a client dies can provide an opportunity for in depth reflection and exploration of the therapeutic encounter. Furthermore, there is great opportunity for further research in the field of existential-phenomenological psychotherapy. It would be particularly interesting to also explore the patients' experiences of receiving existential therapy as it was initially intended and in addition attempt to evaluate the effectiveness of existential-phenomenological therapy in relation to other approaches.

Conclusion

The aim of this study was to offer an understanding of the experience and meaning making of existential practitioners working with clients diagnosed with cancer. In addition, an attempt was made to understand what existential therapy means to practitioners. Outcomes and insights emerged from this study that were not initially intended or expected. The issue of cancer appears to be very powerful, affecting people on several levels mainly due to an automatic link with mortality and death. This was evident for the client, the therapist but also the researcher. As Parkinson (2003) states towards the end of her paper, even reading about those experiences can be overwhelming.

A qualitative methodology and in particular Thematic Analysis (TA) and Interpretative Phenomenological Analysis (IPA) have been used producing a rich experiential account of the experience.

Following a systematic analysis of the data collected, findings indicated the therapists' perceptions of the existential approach as flexible, pluralistic and one that aims at providing openness and breadth by using phenomenological methods. Furthermore, participants reflected upon the emotional impact the work had upon them by awakening of personal losses and cancer-related experiences, causing health anxieties and realisations of their finite nature. Participants also experienced feelings of uncertainty, anxiety and loss from either unexpected endings in therapy or the sudden death of a client. During the process of analysis the uniqueness of this particular encounter

between therapist and cancer client was emphasised. There is a big emotional cost for therapists working with cancer clients and at the same time a sense of fulfilment; a life-learning experience and a feeling of gratification when the client comes to terms with their death.

Ultimately, working with this particular group deviates from what therapists often consider '*usual practice*' in terms of boundaries, therapeutic frame and context. Flexibility appears to be a paramount quality for therapists and also self-reflection seems to have a significant role. Existential issues are inevitably present when working with a client affected by cancer and existential therapists should be prepared to address those with the client but prior to have them explored within themselves.

Despite being a small scale study, this research is thought to have provided useful insights and raised issues for further reflection for existential practitioners, practitioners of other approaches working with clients diagnosed with cancer or other terminal illnesses and practitioners with an interest in existential philosophy and psychotherapy. This study also reminds practitioners of the importance of supervision and therapists' self-care.

Furthermore, this research highlights significant aspects regarding therapists' viewpoints about their actual therapeutic contribution as well as their emotional involvement in the therapeutic process. In particular, the major areas identified portray the therapists' emotional involvement including the therapists' personal history, issues around death

and dying, the impact of the client's physical deterioration and the therapist's existential issues.

Exploring further the therapists' motives to engage in clinical work with clients with cancer would possibly reveal that their choice to work in such settings is a way of finding answers in relation to their own existential concerns such as death and dying. To appreciate and comprehend death itself as well as the process of dying, one needs to seek answers from people who are directly associated with it, in this case cancer patients. Even more valuable is the information from those who have been there and '*returned*' i.e. they have survived.

In the duration of their training existential therapists have explored the existential givens and have been encouraged to resolve them within themselves through their personal development and therapy. However, it seems there is a significant difficulty arising when therapists encounter the issue of death in their therapeutic work. The therapist must face himself/herself and decide whether or not he/she is able to openly address the issue of death and explore it with the client or whether he/she chooses to stay away from it instead of staying with it. When the therapist chooses to '*ignore*' the elephant in the room does that mean that he/she is trying to protect his/her client, or is he/she trying to protect himself/herself?

Being with a client that has come close to his/her death is therefore a challenging experience as it has been revealed from the accounts of the participants. In the occasions

when participants did not address the issue of death openly with their clients, they claimed to have been left feeling there was something more they could have done.

The above also highlights the difference between the existential approach and other psychotherapeutic approaches for instance the cognitive behavioural, where the aim of therapy is not to *be* with the client but to *do*.

From an existential perspective, as the participants in this study have noted, the therapeutic work is a relational way of working involving therapists making use of themselves, being authentic and self-reflective, important qualities for the existential counselling psychologist, in aiding clients with common as well as with more exceptional and perplexed issues, that question the therapist's existentialism at multiple levels both personally and professionally.

I believe that this study contains information and findings that could enrich other practitioners' clinical practice as well as provide ideas for further research. Consequently, its life does not end here but in a new form this study will be published and made available to whoever will be interested in reading it. More specifically, two presentations have been arranged, one at the Greek society for existential therapy and a second one for the staff of the oncology department of a hospital in Athens, Greece.

On a last note, this study has contributed significantly to my personal and professional development on several levels. It has been a very long thought provoking journey allowing for ideas to be re-evaluated and new insights to come to light. There seems to

have been an ongoing parallel process between what therapists observed in the therapeutic process with their clients and the process of our interviews. Being close to people whose life has been threatened seems to have a great emotional impact forcing individuals to review their existential concerns and givens in life.

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Appendices

Appendix 1 – Ethics Application Form

Psychology Department

REQUEST FOR ETHICAL APPROVAL

Applicant (specify): *UG PG (Module:.....) PhD STAFF* *Date*
submitted: 4th June

No study may proceed until this form has been signed by an authorised person, indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials, (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants¹, consent form², or other, including approval by collaborating institutions). A fuller description of the study may be requested.

- Is this the first submission of the proposed study?
Yes/No

- Is this an amended proposal (resubmission)?
Yes/No

Psychology Office: if YES, please send this back to the original referee

- Is this an urgent application? (To be answered by Staff/Supervisor only)
Yes/No

here _____ Supervisor to initial

Name of investigator: Lia Maragou

Name of supervisor: Dr. Elena Manafi

Title of study: *Receiving Existential Therapy following a cancer diagnosis: An existential phenomenological exploration*

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions?
YES/NO

If “yes”, what precautionary steps are to be taken?

It is possible that participants might feel distressed because of the nature of the study. However, everything possible will be done to assure their safety and well being. The researcher will be using her psychological skills and experience to make sure that participants feel supported. Also in case it is considered necessary the interview process will be interrupted.

Finally the participants will be in personal therapy at the time of the interview and their therapist will be aware they are participating in the study.

Please see attached Project Proposal for more information.

3. Will any form of deception be involved that raises ethical issues?

YES/NO

Note: if this work uses existing records/archives and does not require participation per se, tick here

and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

4. If participants other than Middlesex University students are to be involved, where do you intend

to recruit them? (A full risk assessment must be conducted for any work undertaken off university premises)^{6,7}

Participants will be recruited at the Cancer Counselling Service of Mayday Hospital, Croydon, London,

5. Does the study involve

Clinical populations

YES/NO

Children (under 16 years)

YES/NO

Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?

YES/NO

6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? (See consent guidelines²; note special considerations for some questionnaire research)

Informed consent will be obtained by participants themselves.

7. Will you inform participants of their right to withdraw from the research at any time, without penalty? (see consent guidelines²)

YES/NO

8. Will you provide a full debriefing at the end of the data collection phase?

YES/NO

(see debriefing guidelines³)

9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions?

Yes	No
√	
√	
√	

12. Some or all of this research is to be conducted away from Middlesex University

If “yes”, tick here to confirm that a Risk Assessment form is to be submitted

√	
√	
√	

13. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval

√	
---	--

14. I am aware that I need to keep all materials/documents relating to this study (e.g. participant consent forms, filled questionnaires, etc) until completion of my degree

√	
---	--

15. I have read the British Psychological Society’s *Ethical Principles for Conducting Research with Human participants*⁴ and believe this proposal to conform with them

YES/NO

If "no", how do you propose to deal with any potential problems?

10. Under the Data Protection Act, participant information is confidential unless otherwise

agreed in advance. Will confidentiality be guaranteed? (*see confidentiality guidelines*⁵)

YES/NO

If "yes" how will this be assured (*see*⁵)

Please see attached document

If “no”, how will participants be warned? (*see*⁵)

(NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals).

11. Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form?

YES/NO

If “yes” please specify:

(NB: If “yes” has been responded to any of questions 2,3,5,11 or “no” to any of questions 7-10, a full explanation of the

reason should be provided -- if necessary, on a separate sheet submitted with this form).

Researcher Evangelia Maragou

Date 2nd July 2009

Signatures of approval:

Supervisor Dr. Elena Manafi

Date 2nd July 2009

Ethics PanelDate
(signed, pending completion of a Risk Assessment form if applicable)

Appendix 2 – Risk Assessment Form

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

- 1. All fieldwork undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
- 2. All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
- 3. Fieldwork undertaken by research students. Student to complete with supervisor.*
- 4. Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.*

FIELDWORK DETAILS

Name Evangelia Maragou

Student No M00194809

Research Centre (staff only).....

Supervisor Dr. Elena Manafi

Degree course DPsych Existential Counselling Psychology and Psychotherapy

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name ...

Phone ...

Physical or psychological limitations

to carrying out the proposed

None

fieldwork

Any health problems (full details)

None

Which may be relevant to proposed

fieldwork activity in case of

emergencies.

Locality (Country and Region)

London, UK

Travel Arrangements

N/A

NB: Comprehensive travel and health

insurance must always be obtained for N/A
independent overseas fieldwork.

Dates of Travel and Fieldwork N/A

PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment PLEASE READ VERY CAREFULLY

List the localities to be visited or specify routes to be followed (**Col. 1**). Give the approximate date (month / year) of your last visit, or enter 'NOT VISITED' (**Col 2**). For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern (**Col. 3**).

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)

Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.

Demolition/building sites, assault, getting lost, animals, disease.

Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.

Lone working: difficult to summon help, alone or in isolation, lone interviews.

Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.

Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.

Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.

Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.

Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-damage.

Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

Give brief details of fieldwork activity:

Interviews will take place at eh therapist's consulting rooms. In case that is not possible a consulting room will be rent at the following address

1. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
Islington Therapy Centre 187a Northchurch Road N1 3NT London	On completion of the interviews	Lone working

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning and conducting fieldwork.

For each hazard identified (Col 3), list the precautions/control measures in place or that will be taken (Col 4) to "reduce the risk to acceptable levels", and the safety equipment (Col 6) that will be employed.

Assuming the safety precautions/control methods that will be adopted (**Col. 4**), categorise the fieldwork risk for each location/route as negligible, low, moderate or high (**Col. 5**).

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc. If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
Lone working: Interviews will take place at the therapist's consulting room or at the centre mentioned. To control that, interviews will be taking place at daytime when other members of staff are around the service.	Low	Personal alarm

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff) Evangelia Maragou **Date** 4th October 2009

Signature of Student Supervisor Dr. Elena Manafi **Date** 4th October 2009

APPROVAL: (ONE ONLY)

Signature of Curriculum Leader **Date**
(undergraduate students only)

Signature of Research Degree Co-ordinator or Masters Course Leader or Taught Masters Curriculum Leader **Date**

Signature of Research Centre Head (for staff fieldworkers) **Date**

FIELDWORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

N/A Safety knowledge and training?

N/A Awareness of cultural, social and political differences?

✓ Physical and psychological fitness and disease immunity, protection and awareness?

N/A Personal clothing and safety equipment?

N/A Suitability of fieldworkers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

N/A Visa, permits?

✓ Legal access to sites and/or persons?

N/A Political or military sensitivity of the proposed topic, its method or location?

N/A Weather conditions, tide times and ranges?

N/A Vaccinations and other health precautions?

- N/A Civil unrest and terrorism?
- N/A Arrival times after journeys?
- N/A Safety equipment and protective clothing?
- √ Financial and insurance implications?
- N/A Crime risk?
- √ Health insurance arrangements?
- N/A Emergency procedures?
- √ Transport use?
- √ Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix 3 –Ethical clearance

Evangelia Maragou
5-36 Arlington Road
London
NW1 7HU

3 November 2009

Dear Evangelia

Re: Research Proposal Resubmission & Ethics Approval

We held an Ethics Board on 7 October 2009 and the following decision were made.

Research Proposal Resubmission
Resubmission of Research Proposal has been approved.

Ethics Approval
You have been granted ethics approval.

Yours sincerely

Dr Gordon Weller
Programme Leader DProf (Health)
Committee
Middlesex University

Prof Digby Tantam
Chair Ethics

NSPC

Appendix 4 – Participant Information Sheet and Consent Form

*Title of Project: Existential Practitioners' Experience of Working with Clients Diagnosed with Cancer:
An Existential- Phenomenological Exploration*

Name of Researcher: Evangelia Maragou

Participant Information Sheet

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is conducted and what it will involve.

Please take your time to read the following information carefully, and discuss it with the researcher if you wish. Please feel free to ask any questions for further clarification should you need to. Take your time to decide whether or not you wish to take part and feel free to refuse participation if you do not feel comfortable with anything that the study involves.

This study is conducted as part of a Doctoral program in Counselling Psychology at the New School of Psychotherapy and Counselling (NSPC). The purpose of this study is to look at the experiences of existential therapists who have worked with clients diagnosed with cancer. It is believed that the study will be helpful for practitioners working or planning to work with clients diagnosed with cancer through an elucidation and clarification of the issues that emerge out of such work. Your input is therefore much appreciated and valuable.

If you decide to take part in the study you will be asked to attend an interview at a place of your convenience with the researcher which will last for about 60-90 minutes. This interview will be recorded and recording will only be accessible by the researcher and yourself should you wish so.

Questions will attend to your experience of working therapeutically with clients suffering from cancer and will follow a semi structured layout. You will also be given the opportunity to discuss any other issues that might not be covered but are relevant to your personal experience.

All information and data collected about you during the course of the research will be kept strictly confidential and any information used in future publications will be altered so that your anonymity is preserved. This study has been reviewed and given favourable opinion by the Middlesex University Psychology Department's Ethics Committee.

You have the right to withdraw from the study at any point without providing any reasons.

☐

therapyandcancer@googlemail.com

Your reference number is:

Thank you for reading this Information Sheet.

Please feel free to keep this copy.

If you wish to take part in the study please read and sign the consent form.

Appendix 5 – Participant Consent Form

Title of Project: *Existential Practitioners' Experience of Working with Clients Diagnosed with Cancer: An Existential- Phenomenological Exploration*
Name of Researcher: *Evangelia Maragou*

Participant Consent Form

☐

Participant Identification Number:

I consent to take part in this study and I understand that the interview will be taped-recorded, transcribed and anonymized using a numerical code.

1. I confirm that I have read and understood the information sheet dated.....4th October 2009.....

(version...2...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that my personal details and data collected during the study will be looked at by the researcher and staff of Middlesex University marking the study. I give permission for these individuals to have access to my data.

4. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 6 – Interview questions and prompts

Interview questions and procedure

Introduction

Explaining the purpose of the study: to understand your experience of working with clients diagnosed with cancer. Introduce participant information sheet and consent form. Explain confidentiality, anonymity and the right to withdraw at any point.

Exploring the participants way of working

- How would you describe your way of working with clients?
- What does existential therapy mean to you?
- How would you describe your way of working with clients suffering from cancer?

Working with the client diagnosed with cancer

Setting and duration of therapy?

- What is your experience of working with clients diagnosed with cancer?

Any prompts will attend to a clarification of participants' experience.

- Please discuss any issues that came up for you during the therapeutic encounter with your clients.
- How were you affected?

Other areas to explore in the interview

- What comes up for you when working with that client/ client group?

Working with death and other existential issues

- How the therapist encounters the possibility of the client's death as well as his own?

Being faced with the time limitations and the possibility of the client's death

Closing and debriefing:

Thank the participant explore how the interview process was for them. Make sure they feel ok before leaving.

Appendix 7 – Table of emerging themes and sub-themes for all participants

A	B	C	D	E	F
1. Therapist's conceptualisation of the existential approach 1.1 A pluralistic attitude 1.2 Working towards a deliberate way of being 1.3 Existential therapy is the relationship	1. Therapist's conceptualization of the existential approach 1.1 Human beings are always in relation 1.2 Openness & Breadth at the centre of existential practice 1.3 Encounter in therapy: therapist's world meets the client's 1.4 Not just an approach but a way of being 1.5 Heidegger's work irrelevance in working with cancer	1. Working with clients diagnosed with cancer 1.1 Working with the issues people bring 1.2 Role of therapy 1.3 Cancer as a motivation in life 1.4 Impact of time limits in therapy	1. Conceptualisation of therapist's view of existential Therapy 1.1 Using other approaches to cover for the limitations of the Existential approach 1.2 Therapy as a phenomenological exploration 1.3 Exploring the client's world through the 4 dimensions 1.4 Flexibility in order to respond to different needs of clients 1.5 Basic counselling skills promote the change in client's life	1. Construction of therapist's identity: existential approach in practice 1.1 Adopting a flexible humanistic attitude 1.2 Allowing the client to lead 1.3 Daring to address existential issues 1.4 Allowing space for exploration	1. Conceptualisation of the Existential approach 1.1 Influenced by post-modern ideas and phenomenology 1.2 Therapist's view of humans as being always in relation 1.3 Developing a sense of identity through connections 1.4 Adopting a humanistic - relational attitude to therapy 1.5 Being rather than doing
2. Therapist's responses when Death enters the Consulting Room; the Elephant in the Room 2.1 Anxiety and Uncertainty 2.2 Up, Close and Personal; blurring of boundaries 2.3 Departing from the existential attitude 2.4 Could I have done a little more?	2. Implications in work with cancer clients 2.1 Learning about death by working with people who face it 2.2 Additional practical dimensions in work with cancer clients 2.3 Encounter 'Being' 2.4 Seeing the physical deterioration	2. Therapist's personal journey in relation to working with cancer clients 2.1 Being drawn to this work by personal experiences 2.2 Therapist's preparedness and vigilance	2. Therapist's reflections on work with cancer clients 2.1 A learning experience 2.2 Therapist's feeling of achievement from client's change and development 2.3 Themes arising in therapy	2. Therapist's way of being and responses to work with cancer clients 2.1 Working with tensions 2.2 A non-patronising attitude in response to isolation	2. Therapy is a safe space for exploration 2.1 Creating a safe and holding environment 2.2 Encounter and the therapeutic relationship

	2.5 Working with demons and death: Themes in therapy				
	3. Emotional Impact of the work on the therapist 3.1 Unexpected Ending: Feeling left hanging 3.2 Emotionally very heavy 3.3 Becoming aware of presences & absences	3. Emotional impact of uncertainty and clients death 3.1 Loosing touch due to familiarity 3.2 Recognising the need to take time off	3. Impact of this kind of work on therapist 3.1 Struggling to accept the unexpected endings and lack of closure 3.1 Dealing with the awaken experiences 3.3 The possibility of dying is the difference in this kind of work	3. Motivations to work with clients with cancer 3.1 A useful and meaningful work 3.2 Seeking to understand the un-understandable 3.3 A learning experience	3. Issues arising in work with cancer clients 3.1 Working with the diagnosis 3.2 Working with resistance 3.3 Therapy is about trying to speak the unspoken
	4. Encounter: relating to the cancer client 4.1 A very intimate relationship 4.2 The therapist needing to accept too			4. Working with the different responses to cancer 4.1 Cancer as an opportunity 4.2 Feelings and questions arising for therapist and client 4.3 Accepting that not all clients respond the same way	4. Working with the 4 Dimensions 4.1 Clients wanting to protect their relatives 4.2 Working with client's feelings of isolation 4.3 Working in the spiritual dimension 4.4 Working with the physical dimension
	5. Not all black 5.1 Gratifications from the work 5.2 Celebrating life			5. Characteristics of work with cancer clients 5.1 Bearing context in mind 5.2 'Those are psychologically healthy people' 5.3 Different quality in the work	5. Emotional Impact of work on therapist: An opportunity for exploration 5.1 Therapist getting in touch with his mortality 5.2 Working through your own taboos and fears

				<p>5.4 Therapist's feelings on the disjointed nature of the work</p>	<p>5.3 Getting in touch with your own body</p> <p>5.4 Therapist recognising his limitations</p> <p>5.5 Being emotionally touched by the illness</p>
				<p>6. Being affected by this work</p> <p>6.1 A countertransferential -psychosomatic response</p> <p>6.2 Developing health anxieties</p> <p>6.3 Therapist's and clients' lost confidence and autonomy</p>	<p>6. Not all black</p> <p>6.1 Being there in death – a profound experience</p> <p>6.2 The beauty of client's acceptance</p> <p>6.3 Therapist feeling privileged</p>
					<p>7. Different conditions of work than usual</p> <p>7.1 Dealing with responses from relatives</p> <p>7.2 Feelings of working in a hostile environment</p> <p>7.3 A different frame of work</p> <p>7.4 Including a relative in the session</p> <p>7.5 Valuing the limited time</p>

Summary of emerging themes and subthemes for each participant

Appendix 8 – Themes table by participant

Super-ordinate theme	Sub-themes	A	B	C	D	E	F
1. Therapists' conceptualisation of the existential therapy	1.1 A pluralistic attitude offers flexibility to meet clients' individual needs	✓		✓	✓	✓	
	1.2 Encounter and the therapeutic relationship	✓	✓			✓	✓
	1.3 Themes in existential practice	✓	✓		✓	✓	
	1.4 Therapists attitudes to therapy	✓	✓	✓	✓	✓	✓
2. Emotional impact of the work on the therapist	2.1 Dealing with anxiety, uncertainty and unexpected endings	✓	✓	✓	✓		✓
	2.2 Awakening of personal experiences	✓		✓	✓	✓	✓
	2.3 A very close relationship	✓	✓	✓			✓
	2.4 Finding meaning in the work	✓	✓		✓	✓	
3. Implications of clinical practice with clients diagnosed with cancer	3.1 Additional dimensions to be considered regarding this kind of practice	✓	✓	✓			✓
	3.2 Working with existential issues and death being present in the counselling room	✓	✓	✓	✓	✓	✓
	3.3 Working with the physical dimension	✓	✓			✓	✓
	3.4 Therapist's preparedness and vigilance		✓	✓			✓